
# ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

# AHCCCS CONTRACTOR OPERATIONS MANUAL

(ACOM)

**MANUAL OVERVIEW** **PAGE**

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# OVERVIEW

Effective Date: 07/01/05
Revision Date:

Staff responsible for overview: Division of Health Care Management Administration

## I. Purpose

The purpose of the AHCCCS Contractor Operations Manual is to consolidate and provide ease of access to the administrative, claims, financial, and operational policies and requirements of the AHCCCS Administration.

The Manual applies to all Acute Care and Long Term Care Contractors, Arizona Department of Health Services/Behavioral Health Services, Arizona Department of Health Services/Children's Rehabilitation Services, and other entities that have a contract or intergovernmental agreement with AHCCCS to provide covered services (hereinafter referred to as Contractors). This manual also applies to subcontractors who are delegated responsibilities under a contract. As necessary, the policies within the manual specify as necessary the applicability to specific Contractors. This Manual does not replace existing manuals or documents such as those listed in Section IV.

## II. Definitions

The words and phrases contained in the AHCCCS Contractor Operations Manual have the following meanings, unless a chapter or policy contains another meaning.

**Acute Care Contractor:** A contracted managed care organization (also known as a health plan) that provides acute care medical services to AHCCCS members who are Title XIX or Title XXI eligible, and who do not qualify for another AHCCCS program. Most behavioral health services are carved out and provided through the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS).

**Arizona Department of Health Services, Division of Behavioral Health (ADHS/BHS):** A **Prepaid** Inpatient Health Plan mandated to provide behavioral health services to Title XIX acute care and Title XXI members who are eligible for behavioral health services. Services are provided through the ADHS Division of Behavioral Health and its Contractors.

**Arizona Health Care Cost Containment System (AHCCCS)**: The Administration, Contractor, and other arrangements through which health care services are provided to an eligible person, as defined by A.R.S. § 36-2902, et seq.

**AHCCCSA:** The Arizona Health Care Cost Containment System Administration.

**AHCCCS Division of Health Care Management (AHCCCS/DHCM):** The division responsible for Contractor oversight regarding AHCCCS medical program operations, quality and utilization management, financial and operational oversight.

**Arizona Administrative Code (A.A.C.):** Administrative Code, commonly known as rules, is promulgated by State agencies and other entities that prescribe the implementation of statutory intent and requirements.

**Arizona Department of Economic Security, Comprehensive Medical and Dental Plan:** A department within the Arizona Department of Economic Security that is responsible for managing the medical needs of foster children in Arizona under A.R.S. §8-512.

**Arizona Department of Economic Security, Division of Developmental Disabilities (ADES/DDD):** The State agency division responsible for providing services to eligible Arizona residents with developmental disabilities, as defined in A.R.S. Title 36, Chapter 5.1.

**Arizona Department of Health Services (ADHS):** The state agency mandated to serve the public health needs of all Arizona citizens.

**Arizona Department of Health Services, Children's Rehabilitative Services:** A prepaid Inpatient Health Plan administered by the Arizona Department of Health Services. CRS provides services to Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive CRS related services, as defined in 9 A.A.C. 7.

**Arizona Long Term Care System (ALTCS) Contractor:** A contracted managed care organization, that provides long term care, acute care, behavioral health, and case management services to Title XIX eligible elderly, physically or developmentally disabled individuals who are determined to be at risk of an institutional level of care.

**Arizona Revised Statutes (A.R.S.):** The Laws of the State of Arizona.

**Centers for Medicare and Medicaid Services (CMS):** The organization within the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs and the State Children's Health Insurance Program (known as KidsCare in Arizona**)**.

**Code of Federal Regulations (CFR):** The codification of the general and permanent rules established by the executive departments and agencies of the federal government.

**Contractor:** A Managed Care Organization providing health care services to acute or long term care members and/or a Prepaid Inpatient Health Plan providing behavioral health services to eligible acute care members and/or CRS related services to eligible acute or long term care members.

## III. Policy

The Division of Health Care Management (DHCM), in conjunction with other divisions within AHCCCS, is responsible for the formulation of policy for the AHCCCS Contractor Operations Manual. Stakeholder input is sought as appropriate. Policy changes may stem from several sources, including but not limited to recently promulgated or revised federal and state regulations, program contract changes, changes in accepted business standards of practice, and internal or external discussions.

## IV. References

As appropriate, this Manual provides reference to other AHCCCS manuals, legal references or documents, which provide more detailed information. These include, but are not limited to:

1. 1115 Waiver
2. AHCCCS State Plan
3. Code of Federal Regulations (CFR)
4. Arizona Revised Statutes (ARS)
5. Arizona Administrative Code (Rules)
6. AHCCCS Contracts
    a. Acute Care
    b. Arizona Long Term Care System (ALTCS)
    c. Behavioral Health Services
    d. Children's Rehabilitation Services
    e. Arizona Department of Economic Security Children's Medical and Dental Program
7. AHCCCS Medical Policy Manual (AMPM)
8. Encounter Reporting User Manual
9. Reinsurance Claims Processing Manual
10. Provider Affiliation Tape Manual
11. Claims Reporting Guide

## V. Contact

Revisions to the Manual are published on the AHCCCS web site, which can be accessed at www.ahcccs.state.az.us. Updates for the web site occur on a monthly or as-needed basis.
Any questions concerning the **content** of the AHCCCS Contractor Operations Manual should be addressed to:

AHCCCS Division of Health Care Management
701 E. Jefferson, Mail Drop 6100
Phoenix, AZ 85034

Attention to:

| **Content Area** | **Contact** | **Telephone number** | **E-mail** |
|---|---|---|---|
| Acute Care | Carol Smallwood | 602-417-4362 | Carol.Smallwood@azahcccs.gov |
| ALTCS | Alan Schafer | 602-417-4614 | Alan.Schafer@azahcccs.gov |
| Finance | Kathy Rodham | 602-417-4568 | Kathy.Rodham@azahcccs.gov |

Any questions concerning the **technical aspects** of the AHCCCS Contractor Operations Manual should be addressed to:

Lorraine Oliver
AHCCCS Division of Health Care Management
701 E. Jefferson, Mail Drop 6100
Phoenix, AZ 85034
Telephone: 602-417-4104
E-mail: Lorraine.Oliver@azahcccs.gov
Fax: 602-256-6421

## CHAPTER 100 – ADMINISTRATION PAGE

# 101 - MARKETING OUTREACH AND INCENTIVES

Effective Date: 10/10/93
Revision Date(s): 12/01/03

Staff responsible for policy: DHCM Operations

## I. Purpose

This policy applies to Acute Care and Arizona Long Term Care System (ALTCS) Contractors. In addition to the requirements of R9-22, Article 5 for Acute Care, R9-31, Article 5 for KidsCare, and R9-28, Article 5 for the Arizona Long Term Care System (ALTCS). This policy establishes guidelines and restrictions for all Contractors, awarded a contract or under contract with AHCCCS to deliver health care services, for marketing and outreach activities related to the AHCCCS program. Contractors are encouraged to focus marketing efforts on various forms of outreach, which encourage the appropriate use of health care services or provide educational materials.

## II. Definitions

**Health education:** Programs, services or promotions that are designed or intended to advise or inform the Contractor's actual or potential members about the issues related to healthy lifestyles, situations that affect or influence health status, behaviors that affect or influence health status or methods or modes of medical treatment.

**Health education materials:** Collateral materials that are designed, intended, or used for health education or outreach by the Contractor. Health education materials include, but are not limited to, general distribution brochures, member newsletters, posters, and member handbooks.

**Incentives:** Items that are used to encourage behavior changes in individuals. The policy covers three categories of incentives:

1. Enrollment incentives to encourage potential members to apply for AHCCCS services

2. Contractor incentives to encourage potential members to choose a particular Contractor, and

3. Health promotion incentives to motivate members to adopt a healthy life style and/or obtain health care services. These may include infant car seats, discounts for merchandise or services and manufacturer or store coupons for savings on products or services or any other objects that are designed or intended to be used in health education or outreach. Incentives may not be used in conjunction with the distribution of alcohol or tobacco products.

**Marketing:** Any medium of communication, written, oral, or electronic, whereby the intent of such medium is to increase the Contractor's membership. Marketing also includes any promotional activities.

**Marketing materials:** General audience materials such as general circulation brochures, advertising copy, Contractor's Web site and collateral materials that are designed, intended, or used for increasing Contractor membership. Such marketing materials may include, but are not limited to: scripts or outlines for member services representatives, letters to AHCCCS members, provider directories, newsletters, newspaper advertisements, billboards and billboard layouts, radio scripts and advertisements, direct mail materials or stuffers, brochures or leaflets that are distributed or circulated by any third party (including providers), and posters.

**Outreach:** Any means of educating or informing the Contractor's actual or potential members about health issues. See "health education".

**Outreach materials:** See "health education materials".

**Promotion:** Any activity in which materials are given away where the intent is to increase the Contractor's membership.

**Promotional materials:** Objects, services, or materials that are designed or intended to be given away by the Contractor to actual or potential members. Promotional materials may be intended for marketing.

**Provider:** A hospital and hospital staff, a physician and physician office staff, a pharmacy and a pharmacist, and/or ancillary service providers and their staff.

## III. Policy

### A. Submission of Materials

All materials, including those pertaining to health education, incentives, marketing, outreach, and promotions, must be prior approved by the AHCCCS Marketing Committee. Refer to the Division of Health Care Management (DHCM) Member Information Policy when developing materials for members. Proposed material (including the cost of outreach or marketing "give-away" items) shall be submitted to:

Manager, Health Plan Operations (or her/his designee)
Division of Health Care Management, Mail Drop 6100
701 East Jefferson
Phoenix, AZ 85034
FAX: (602) 256-6421

Proposed material must be submitted no later than 30 days prior to the desired date of dissemination. AHCCCS will attempt to notify the Contractor in writing within 15 working days of receipt of the complete materials packet whether or not the proposed materials have been approved, denied or require modification. If a Contractor wishes to contest AHCCCS' decision, it may do so by filing a grievance in accordance with Title 9, Chapter 34 of the Arizona Administrative Code (9 A.A.C. 34). The Contractor may request an accelerated hearing.

Any changes or amendments to the approved marketing materials (e.g., prior billboard ad approved, but subsequently modified) must also be submitted in advance to AHCCCS for approval and are subject to the same policies as described above. Approval shall only apply to the form of communication described with the initial submission. For example, verbiage approved for a billboard is not considered approved if used in a brochure.

## B. Marketing Costs

All Contractors will be required to report their marketing costs on a quarterly basis as a separate line item in the quarterly financial statements. This requirement also applies to any marketing costs included in an allocation from a parent or other related corporation.

All marketing costs allocated and otherwise, will be excluded in the determination of capitation rate ranges. Additionally, any Contractor not in compliance with the AHCCCS viability criteria indicators, as defined in the contract, may be restricted from further marketing until the Contractor is in compliance with the viability criteria indicators.

## C. Restrictions

1. The following shall *not* be allowed for marketing:

    a. Incentive items such as t-shirts, buttons, balloons, key chains, etc. unless the intent of such a give-away is outreach in nature (i.e., for educating members about the benefits of safety, immunizations, or well-care). All incentive items must be prior approved by the AHCCCS Marketing Committee.

    b. Solicitation of any individual face-to-face, door-to-door, or over the telephone

    c. References to competing plans

    d. Promotional materials, incentives, or any other activity to influence enrollment in conjunction with the sale or offering of any private insurance

e. Television advertising

f. Direct mail advertising

g. Marketing of non-mandated services

h. Utilization of the word "free" in reference to covered services

i. Listing of providers in marketing and open enrollment materials who do not have signed contracts with the Contractor

j. Use of the AHCCCS logo

k. Inaccurate, misleading, confusing or negative information about AHCCCS or the Contractor; and any information that may defraud members or the public

l. Discriminatory marketing practices as specified in the Arizona Administrative Code 9 A.A.C. 22, Article 5, 9 A.A.C. 28, Article 5, 9 A.A.C. 31, Article 5

2. AHCCCS reserves the right to impose additional restrictions.

3. The Contractor shall ensure that:

a. Any outreach or incentive item given away by the Contractor to its members shall not exceed $50.00. Any marketing item given away by the Contractor shall not exceed $10.00. (The total cost of all marketing and outreach/incentive items given to each member household, at each event, may not exceed $50.00.)

b. All marketing materials identify the Contractor as an AHCCCS provider and are consistent with the requirements for information to members described in the RFP and AHCCCS policies.

c. All marketing materials that have been produced by the Contractor and refer to contract services shall specify such services are funded in part under contract with the State of Arizona.

d. All marketing materials that are distributed by the Contractor, shall be distributed to its entire contracted geographic service area.

e. Contractors or staff shall not assist potential members in completing eligibility applications. This prohibition covers all situations, whether sponsored by the Contractor, their parent company, or any other entity.

f. Subcontractors are advised that they must comply with this policy. Failure of a subcontracted provider to adhere to this policy may result in sanctions/penalties to the Contractor contracted with such a provider.

**D. Sanctions/Penalties**

Any violations of this policy may result in:

1. Financial sanctions not to exceed five percent per month of monthly capitation, and/or

2. Immediate suspension of all forms of marketing for a period not to exceed six months, and/or

3. Placement of an enrollment cap, or

4. Termination of contract

**E. Review**

Contractors shall review all their marketing materials on a regular basis in order to revise materials, if necessary, to reflect current practices. Contractors shall refer all marketing materials for review and approval to the AHCCCS Marketing Committee. The AHCCCS Marketing Policy will be reviewed and approved by the State Medicaid Advisory Committee and administered by the AHCCCS Marketing Committee.

**F. Marketing Attestation**

The Contractor CEO (or designee) shall sign the Marketing Attestation Statement within 45 days of the beginning contract year. See Attachment A.

## IV. References

- 42 CFR 434.36
- Arizona Administrative Code 9 A.A.C. 22, Article 5, 9 A.A.C. 28, Article 5 and 9 A.A.C. 31, Article 5
- AHCCCS contract

**ATTACHMENT A**

*JANET NAPOLITANO,* GOVERNOR
*ANTHONY D. RODGERS,,* DIRECTOR

***801 EAST JEFFERSON, PHOENIX AZ 85034***
***PO BOX 25520, PHOENIX AZ 85002***
*PHONE* ***602 417 4000***
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AHCCCS

*OUR FIRST CARE IS YOUR HEALTH CARE*
**arizona health care cost containment system**

## MARKETING ATTESTATION STATEMENT

The oral and written information given to potential members by the Contractor is accurate in order for members to make an informed decision on whether to enroll with a specific Contractor.

All information potential members are given has been approved by the AHCCCS Marketing Committee and is in compliance with the AHCCCS Division of Health Care Management Marketing, Outreach, and Incentives Policy.

_____
Signature of Authorized Representative

_____
Title

_____
CONTRACTOR

_____
Date

Please sign, date, and then return to:

Michael Veit, MD 5700
AHCCCS Contracts and Purchasing
701 E. Jefferson St.
Phoenix AZ 85034

# 102 - DISTRIBUTION OF GRADUATE MEDICAL EDUCATION MONIES AFTER 1997

Effective Date: 07/21/97
Revision Date: 11/29/02

Staff responsible for policy: DHCM Finance

## I. Purpose

### Scope
This policy describes the methodology for distributing graduate medical education (GME) monies for hospital services after September 30, 1997.

This policy does not provide for additional funding due to the development of new programs initiated after April 1, 1997 or changes in the size of existing GME programs, and is in effect until the legislature provides an alternate distribution methodology for GME.

### Applicability
This policy applies to AHCCCS registered hospitals with GME programs that were approved by the AHCCCS Administration (AHCCCSA) as of October 1, 1999.

### Background
This distribution methodology is established pursuant to A.R.S. §36-2903.01, which states:

"Beginning September 30, 1997, the Administration shall establish a separate graduate medical education program to reimburse hospitals that had graduate medical education programs that were approved by AHCCCSA as of October 1, 1999. The Administration shall separately account for monies for the graduate medical education program based on the total reimbursement for graduate medical education reimbursed to hospitals by the system in Federal Fiscal Year (FFY) 1995-1996 pursuant to the tiered per diem methodology specified in this section. The graduate medical education program reimbursement shall be adjusted annually by the increase or decrease in the index published by the Data Resources Incorporated Hospital Market Basket Index for Prospective Hospital Reimbursement. Subject to legislative appropriation, on an annual basis, each qualified hospital shall receive a single payment from the graduate medical education program that is equal to the same percentage of graduate medical education reimbursement that was paid by the system in FFY 1995-1996. Any reimbursement for graduate medical education made by the Administration shall not be subject to future settlements or appeals by the hospitals to the Administration."

## II. Definitions

**Graduate Medical Education (GME):** Accredited M.D. and D.O. programs provided in conjunction with hospitals participating in the AHCCCS program.

## III. Policy

To determine the total GME fund for FFY98, the total amount of GME payments made by the AHCCCS Administration to hospitals in FFY96 shall be inflated by the Data Resources Incorporated (DRI) market basket for prospective payment hospitals for FFY97 and for FFY98. Each year thereafter, the total GME fund shall be adjusted as defined by legislation.

For FFY98, and each year thereafter, the GME fund distribution shall consist of two calculations based on the status of the GME program, i.e., hospitals with established GME programs receiving a GME payment in FFY96, and hospitals with "new" GME programs that did not receive GME payments in FFY96, but for which legislation allowed them to enter the GME fund distribution.

GME Fund distribution will be as follows:

1. Hospitals with GME programs receiving AHCCCS payments in FFY96 shall receive a GME payment directly from AHCCCS each year. The total of this payment shall be based on the percentage of the total FFY96 GME fund that their FFY96 GME payment represented.

   For example: If Hospital “A” received 10% of the total GME fund in FFY96, then Hospital “A” will receive approximately 10% of the total GME fund in each of the subsequent years. The amount is approximate because payments made to hospitals with "new" GME programs will slightly impact the GME payments received by hospitals with existing programs.

2. Hospitals with "new" GME programs shall also receive a GME payment directly from AHCCCS each year. The total of that payment shall be based on the percentage of the total FFY96 GME fund that their initial GME payment represented.

   For example: If Hospital “C” received their initial GME payment in FFY97, and that payment represented 2% of the total GME fund in FFY96, then Hospital “C” will receive 2% of the total GME fund in each of the subsequent years.

The same method applies to "new" programs that receive initial GME payments in FFY98 or thereafter.

As such, until new legislation is passed, "new" GME programs shall take away from the GME funds available to existing GME programs.

## IV. References

- Arizona Revised Statute §36-2903.01

This policy supports the guidelines presented by the Office of Intergovernmental Relations. Revisions to this policy are under the authority of the Assistant Director of the Division of Health Care Management/Finance.

# 103 - FRAUD AND ABUSE POLICY

Effective Date: 10/01/94
Revision Date: 10/01/03

Staff responsible for policy: DHCM Administration

## I. Purpose

This policy applies to all Acute Care and Long Term Care Contractors, Arizona Department of Health Services/Behavioral Health Services. Arizona Department of Health Services/Children's Rehabilitation Services, and other entities that have a contract or Intergovernmental Agreement with AHCCCS to provide covered services (hereafter referred to as Contractors). This manual also applies to subcontractors who are delegated responsibilities under a contract. Its purpose is to prevent the occurrence of abuse of members and member and provider fraud and abuse within the AHCCCS program. The AHCCCS Office of Program Integrity is the office of primary responsibility for conducting investigations and inquiries relating to fraud, waste and abuse as it pertains to providers and members.

The objectives of this policy are to:

A. facilitate the reporting of potential fraud and abuse cases to AHCCCSA for investigation; and
B. require Contractors to work with AHCCCSA (i.e., via workgroup) to further develop prevention and detection mechanisms (i.e., best practices) for Medicaid managed care.

It is anticipated that this policy will be updated as Federal and State requirements are more specifically defined for fraud and abuse in a managed care setting, and as AHCCCSA and Contractors are better able to identify and scrutinize prevention and detection of managed care fraud and abuse. The AHCCCSA will work with Contractors in a joint effort to better define Medicaid managed care fraud and abuse, the applicability of federal requirements, and how best to prevent and/or detect fraud and abuse.

## II. Definitions

**Abuse of a member:** Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual or emotional abuse or sexual assault. (A.R.S. § 46-451 and 13-3623)

**Abuse by a provider:** Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program. (42 CFR 455.2)

**Fraud by a member or provider:** Intentional deception or misrepresentation made by a person or persons with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 455.2)

**Compliance Officer:** The on-site official designated by each Contractor to implement, oversee and administer the Contractors' compliance program including fraud and abuse control. The Compliance Officer shall be an on-site management official, available to all employees, with designated and recognized authority to access and provide records and make independent referrals to the AHCCCSA Office of Program Integrity.

**Provider:** Any entity or individual providing health care or other services.

## III. Policy

### A. Prevention/Detection

Contractors shall have in place, internal controls, policies and procedures that are capable of preventing, detecting, and reporting fraud and abuse activities. For example, operational policies and controls such as claims edits, prior authorization, utilization and quality review, provider profiling, provider education, post-processing review of claims, adequate staffing and resources to investigate unusual incidents, and corrective action plans can assist Contractors in preventing and detecting potential fraud and abuse activities.

More detailed descriptions of the controls that Contractors should consider are contained in the document AHCCCS Contractors Fraud and Abuse Prevention/Detection Summary (Attachment A).

**B. Reporting**

If a Contractor discovers, or is made aware, that an incident of potential/suspected fraud and abuse has occurred, the Contractor shall report, within 10 business days of the discovery, the incident to AHCCCSA by completing the confidential AHCCCS Referral For Preliminary Investigation form (Attachment B). Timely reporting of fraud and abuse improves the likelihood of a successful investigation and prosecution.

The same form shall be used for abuse of members referrals as well as referrals for provider and member fraud and abuse.

1. Abuse of Member Referrals

   The form and its attachments shall be submitted to:

   AHCCCS, Division of Health Care Management
   Clinical Quality Management Unit
   701 E. Jefferson, Mail Drop 6500
   Phoenix, AZ 85034
   FAX (602) 417-4162

2. Fraud and Abuse by Providers or Members

   The form and its attachments shall be submitted to:

   AHCCCS, Office of Program Integrity
   801 E. Jefferson, Mail Drop 4500
   Phoenix, AZ 85034
   FAX (602) 417-4102

All pertinent documentation and/or investigative reports that would assist AHCCCSA in its investigation shall be attached to the forms.

### C. Compliance Officer Responsibilities Related to Fraud and Abuse

1. Oversee, monitor and be the focal point for the Contractor's compliance program, with the authority to review all documents and functions as they relate to fraud and abuse prevention, detection and reporting such as provider registration, prior authorization and contracts

2. Maintain and monitor a tracking system of fraud and abuse

3. Have the authority to independently refer potential member and provider fraud and abuse cases to AHCCCSA

4. Be an on-site management official who reports directly to the organization's CEO, COO or equivalent, on a regular periodic basis, regarding all fraud and abuse issues including policy matters, cases and training

5. Have direct access to the CEO and/or the governing body, senior management and legal counsel

6. Ensure all employees, providers and members receive adequate training/information by overseeing a comprehensive training program, which addresses fraud and abuse prevention, recognition and reporting, and encourages employees, providers, and members to report fraud and abuse without fear of retaliation

7. Ensure an internal reporting procedure that is well defined and made known to all employees

8. Periodically review and revise the fraud and abuse policies to meet changing regulations or trends, and

9. Regularly attend and participate in AHCCCS, Office of Program Integrity work group meetings

### D. Other State and Federal Regulations

In addition to the specific requirements stated above, it is required that Contractors be in compliance with all State and Federal regulations related to fraud and abuse not directly detailed in this policy.

## IV. References

- Section 1903(q) of the Social Security Act
- Title 42 of the Code of Federal Regulations (42 CFR) 1007.1 through 1007.21
- 42 CFR 455.1 through 455.23
- Arizona Revised Statutes (A.R.S.) § 46-451
- A.R.S. § 13-3623
- Arizona Administrative Code R9-22, Article 5

**ATTACHMENT A**

# AHCCCS CONTRACTORS FRAUD & ABUSE PREVENTION/DETECTION ACTIVITIES SUMMARY

| PREVENTION / DETECTION / CONTROL | PURPOSE |
|---|---|
| **AHCCCS CONTRACTORS:**<br><br>◈ Each Contractor should have a corporate culture, which encourages its employees to detect and report fraud and abuse.<br><br>◈ Contractors should establish procedures for the prevention, detection and reporting of fraud and abuse.<br><br>◈ Should a Contractor be made aware of any activities that may involve member or provider fraud, the fraud section shall immediately notify AHCCCS as described in AHCCCS policy.<br><br>◈ Contractors should assist governmental agencies as practical in providing information and other resources during the course of investigations of possible fraud and abuse. | ◈ Create an environment conducive to preventing and detecting fraud and abuse. |
| **CONTRACTOR EMPLOYEES:**<br><br>◈ Contractors should implement lines of reporting for possible fraud and abuse that are well defined and made known to all employees through new employee orientation.<br><br>◈ Employees that interact with providers and members should be trained in fraud and abuse detection and reporting. These employees must be familiar with the types of fraud and abuse which could be encountered and the steps to report any such noted fraud or abuse.<br><br>◈ Those employees that interact with providers and members shall watch for signs of potential fraud and abuse such as the abuse, neglect or exploitation of an eligible person and/or the loss, theft, misappropriation, or overpayment of AHCCCS and/or Contractor funds. | ◈ Increase employees' awareness of what fraud is, how to find it, their responsibilities, and how to report it. |

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| **MEMBER SERVICES:**<br><br>◈ Through the member handbooks, Contractors can encourage members to report providers that may be providing unnecessary or inappropriate services. Include directions of how to report information to the Contractor.<br><br>◈ Establish a member complaint system, which logs and documents all complaints. All complaints should be reviewed timely and resolved. Any complaints, which involve fraud or abuse, should be handled in accordance with the Contractors' reporting structure.<br><br>◈ Member handbooks should include a definition of member fraud and abuse with reference to penalty for fraud and abuse under law. | ◈ Identify possible fraud from member reporting and member complaints.<br><br>◈ Discourage member fraud by informing members of penalties associated with fraud and abuse. |
| **PROVIDER SERVICES:**<br><br>◈ The credentialing/certification process (including re-credentialing) must ensure a careful review of all participating providers. Providers considering participation in the contract must complete a pre-application, which is reviewed by Contractor personnel.<br><br>◈ Credentialing criteria include, but are not limited to (1) a complete, accurate and verified application, (2) a current Arizona professional license, (3) proof of completion of education and training commensurate with the provider's field of practice, (4) a review of any history of limitations, suspensions or restrictions of privileges, and (5) a review of any felony convictions, substance abuse, and suspensions or terminations from the Medicaid or Medicare programs and/or debarment from the Department of Health and Human Services.<br><br>◈ Contractors shall monitor providers for non-compliance with Contractors' and/or AHCCCS rules, policies and procedures. | ◈ Prevent fraudulent use of the Medicaid system by disbarred, unlicensed, unqualified, and otherwise inappropriate providers.<br><br>◈ Avoid possible fraud by monitoring providers for compliance with Contractor and AHCCCS rules, policies & procedures. |

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| **GRIEVANCE AND APPEALS:**<br><br>Grievances are tracked by type and referred to appropriate personnel. | ◈ **Detect possible abuse of members, by a provider, or patterns of inappropriate utilization, referrals, etc.** |
| **CONTRACTING WITH PROVIDERS:**<br><br>◈ Provider contracts there must include specific sections describing the provider's responsibilities to (1) comply with all applicable Federal, State and local laws, rules and regulations, (2) notify the Contractor of any credentialing/licensure change, (3) maintain professional standards, (4) maintain and furnish records and documents as required by law, rule and regulation, and (5) abide by applicable laws, rules, regulations and contract provisions to avoid termination of the contract, and (6) other AHCCCS subcontract provisions, as appropriate.<br><br>◈ By educating providers to bill correctly, Contractors can discourage the submission of claims for non-covered or unnecessary services.<br><br>◈ Provider manuals should include a section about fraud and abuse, which includes references to provider fraud and abuse and member fraud, and abuse. The manual should describe how providers can report potential cases of fraud and abuse to the Contractor.<br><br>◈ Contracts should also include anti-kickback language and reference to self-referrals in each of its standard contract forms. | ◈ Reduce possibility of provider fraud by making provider aware of applicable rules, regulations, etc. during contract process.<br><br>◈ **Avoid possible fraud by educating providers about how to bill appropriately** |
| **PRIOR AUTHORIZATION:**<br><br>◈ The Prior Authorization Department should be the beginning of a continuous series of review for medical services. These responsibilities include, but are not limited to, verifying (1) member eligibility, (2) medical necessity, (3) appropriateness of service being authorized, (4) the service being requested is a covered service, and (5) appropriate provider referral.<br><br>◈ Any portion of the prior authorization request, which is deemed an "unusual incident", should immediately be written up and referred to the appropriate personnel. | ◈ To avoid possibility of member or provider abuse, such as over or under utilization. |

| | |
|---|---|
| **CLAIMS SYSTEM:**<br><br>◈ Claims Edits: During the initial processing of a claim, the claim should be reviewed for items such as member eligibility, covered services, excessive or unusual services for sex or age, duplication of services, prior authorization, invalid procedure codes, and duplicate claim. Any unusual items should cause the claim to pend for review. Also, claims over a certain amount should automatically be pended for review.<br><br>◈ Post Processing Review of Claims: After claims are paid, retrospective review of a sample of claims is done to determine the following: (1) reasonable charges were made for services provided, (2) the appropriateness of inpatient and outpatient care, (3) the appropriate level of care, (4) excessive diagnostic testing or ancillary referrals.<br><br>◈ Contractors should also conduct audits of claims payments to attain a reasonable assurance that payments are being prepared correctly for claims submitted from authorized providers for eligible AHCCCS members. | ◈ Prevent/detect payments to providers for services not performed, not authorized, or otherwise inappropriate.<br><br>◈ Test for validity of the original claims process for detecting fraud and misuse. |
| **UTILIZATION/QUALITY MANAGEMENT:**<br><br>Utilization/Quality Management controls include (1) prior authorization and/or pre-admission review, (2) admission review, (3) concurrent review, (4) discharge review, and (5) retrospective review.<br><br>Utilization reports (provider and member profiling) should be monitored to determine if a specific provider or member shows unusually high or low levels of service utilization.<br><br>If at any time during the utilization/quality management process an "unusual incident" should be suspected or discovered, the matter would be immediately referred to the appropriate personnel.<br><br>Regularly scheduled medical record audits and site reviews are conducted. | ◈ To reduce possibility of provider and member abuse, such as over or under utilization. |

REVISED: 06/12/00

C O N F I D E N T I A L

**OPI Case #**_____

## AHCCCS REFERRAL FOR PRELIMINARY INVESTIGATION

**Suspected Program Fraud or Abuse and Member Fraud:** Refer to: Director, Office of Program Integrity, 801 E. Jefferson, Mail Drop 4500 Phoenix, AZ 85034 (602) 417-4045 / **FAX** (602) 417-4102, **or Toll Free** 1-800-654-8713 ext. 7-4045

***SEE DEFINITIONS AND EXAMPLES OF FRAUD & ABUSE ON THE REVERSE SIDE***

### *Referral Source*

**Name & Title of Individual Referring:**_____

_____

Date of Referral _____

Phone Number _____ Return Call Needed to Referring Individual __YES __NO

***Referring Individual is Affiliated With***: NAME_____

- ❑ AHCCCS Contractor
- ❑ Government Agency
- ❑ Health Care Provider
- ❑ Recipient/Recipient Family
- ❑ Other (Anonymous, Citizen, etc.) _____

**Name of Individual actually reporting the incident, (if different that of the referring individual above):**

_____**Phone Number**_____

### Provider/Caregiver ~ Recipient ~ AHCCCS Contractor *allegedly involved* in the Issue:

Provider/Caregiver or AHCCCS Contractor Information:

**NAME**_____ **AHCCCS Provider ID #** _____

**Address and Phone #** _____

Recipient/Member Information (if applicable and available):

**NAME**_____ **AHCCCS ID or Social Sec. #** _____

**Date of Birth**_____ **Address and Phone #** _____

**NARRATIVE DESCRIPTION OF ISSUE:** *(Please include the **Who, What, Where**, and **When** of the issue).*
*PLEASE DO NOT USE ABBREVIATIONS*
*Dollar Loss to the program (if known) $*_____

(Narrative may be continued on the reverse side.)

Narrative continued:

_____

_____

_____

_____

**AGENCIES NOTIFIED:** ❑ APS ❑ CPS ❑ ADHS LICENSURE ❑ POLICE ❑ Other _____

**Comments:**_____

## DEFINITIONS

AHCCCS CONTRACTOR **means an AHCCCS Health Plan, Program Contractor, Arizona Department of Health Services/ Behavioral Health Services, Regional Behavioral Health Authorities, Arizona Department of Health Services/Children's Rehabilitation Services and any other entity that has a contract or Intergovernmental Agreement with AHCCCS to provide covered services.**

FRAUD **means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.** ***[42 CFR § 455.2]***

ABUSE **means provider practices that are inconsistent with sound fiscal, business, or medical practice, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.** ***[42 CFR § 455.2]***

ABUSE OF A MEMBER **means any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault.** ***[ARS § § 46-451;13-3623]*** *REPORT MEMBER ABUSE TO: AHCCCS/DHCM-CQM, 701 E. JEFFERSON, MD-6500, Phoenix, AZ 85034*

## EXAMPLES OF FRAUD AND ABUSE

**FALSIFYING CLAIMS/ENCOUNTERS**

Alteration of a Claim
Upcoding
Incorrect Coding
Double Billing
Unbundling
Billing for Services/Supplies Not Provided
Misrepresentation of Services/Supplies
Substitution of Services
Submission of Any False Documents

**ADMINISTRATIVE / FINANCIAL**

Kickbacks/Stark Violations
Fraudulent Credentials
Fraudulent Enrollment Practices
Fraudulent Recoupment Practices
Embezzlement

***Delivery of Services***

Denying Access to Services/Benefits
Limiting Access to Services/Benefits
Failure to Refer to a Needed Specialist
Underutilization
Overutilization

**ABUSE OF A MEMBER**

Physical Abuse
Neglect
Mental Abuse
Emotional Abuse
Sexual Abuse
Discrimination
Providing Substandard Care
Financial Exploitation

***Member Fraud***

Eligibility Determination Issues:
Resource Misrepresentation (Transfer/Hiding)
Residency
Household Composition
Income
Citizenship Status
Misrepresentation of Medical Condition

Please note, the above lists only a *few* examples of potential fraud and abuse scenarios. Revised: 10/10/03

# 104 – BUSINESS CONTINUITY AND RECOVERY PLAN

Effective Date: 10/01/04
Revision Date:

Staff responsible for policy: DHCM Administration

## I. Purpose

This policy applies to all Acute Care and Long Term Care (ALTCS) Contractors, Arizona Department of Health Services/Behavioral Health Services (ADHS/BHS), Arizona Department of Health Services/Children's Rehabilitation Services (CRS), and any other entity that has a contract or Intergovernmental Agreement with AHCCCS to provide covered services (hereinafter referred to as Contractors).

AHCCCS requires in contract that each of its Contractors have a Business Continuity Plan. The purpose of this policy is to outline the required components of the Plan and also suggested checklists and plan testing methods.

AHCCCS is mandated to provide health care benefits to its enrollees. It does so through contracts with Acute and ALTCS Contractors and ADHS/BHS, through a network of providers for fee-for-service enrollees, but also recover from the disruption as quickly as possible. This recovery can be accomplished by the development of a Business Continuity Plan that contains strategies for recovery.

## II. Definition

**Contractor:** Refers to Acute Care and Long Term Care (ALTCS) Contractors, Arizona Department of Health Services/Behavioral Health Services (ADHS/BHS), Arizona Department of Health Services/Children's Rehabilitation Services (CRS), and any other entity that has a contract or Intergovernmental Agreement with AHCCCS to provide covered services (hereinafter referred to as Contractors).

## III. Policy

A. Each Contractor shall have a Business Continuity and Recovery Plan.

B. The Business Continuity and Recovery Plan shall be reviewed at least annually and updated as needed by the Contractor.

C. The Contractor shall ensure that its staff is trained and familiar with the Plan.

D. The Plan should be specific to the Contractor's operations in Arizona and reference local resources. Generic Plans which do not reference operations in Arizona and the Contractor's relationship to AHCCCS are not appropriate.

E. The Plan shall contain a listing of key customer priorities, key factors that could cause disruption, and what timelines Contractors will be able to resume critical customer services. Examples of these priorities are: Providers receipt of prior authorization approvals and denials, members receiving transportation, timely claims payments, etc.

F. The Plan shall contain specific provisions for recovery of key customer priorities.

G. The Plan shall contain specific timelines for resumption of services. The timelines should note the percentage of recovery at certain hours, and key actions required to meet those timelines. An example of this would be: Telephone service restored to prior authorization unit within 4 hours, to Member Services within 24 hours, to all phones in 24 hours, etc.

H. The Plan shall contain, at a minimum, planning and training for:

- Electronic/telephonic failure at the Contractor's main place of business.
- Complete loss of use of the main site and any satellite sites.
- Loss of primary computer system/records, or networks.
- How the Contractor will communicate with AHCCCS during a business disruption. The name and phone number of a specific contact in the Division of Health Care Management is preferred. The plan should direct the contractor staff to contact AHCCCS Security at 602-417-4888 in the event of a disruption outside of normal business hours.

I. The Plan should include provisions for periodic testing, at least annually. Results of the tests shall be documented.

J. All Contractor Plans shall be subject to review and approval by AHCCCS Administration. A summary of the plan, with emphasis on the components from Paragraph H of this section, shall be submitted to the Division of Health Care Management 15 days after the start of the contract year and annually thereafter. The summary shall be no longer than 5 pages and include timelines for recovery.

K. Each Contractor shall designate a staff person as Business Continuity Planning Coordinator and furnish AHCCCS with that contact information.

## IV. References

The Federal Emergency Management Agency (FEMA) has a website which contains additional information on Business Continuity Planning, including a checklist for reviewing a Plan.

AHCCCS encourages the Contractor to use relevant parts of this checklist in the evaluation and testing of its own Business Continuity Plan. The website is located at http://www.fema.gov/ofm

## V. Authority

AHCCCS Acute Care, ALTCS, and ADHS/BHS Contracts require Contractors to have a Business Continuity Plan.

## CHAPTER 200 – CLAIMS PAGE

# 201 - MEDICARE COST SHARING FOR MEMBERS IN MEDICARE FFS

Effective Date: 10/01/97
Revision Date: 06/01/01

Staff responsible for policy: DHCM Finance

## I. Purpose

This policy applies to AHCCCS acute care Contractors, Arizona Long Term Care System (ALTCS) Contractor and the Arizona Department of Health Services (ADHS) for Title XIX behavioral health services, hereafter known as Contractors.

The purpose of this policy is limited to and defines cost sharing responsibilities of AHCCCS Contractors for their members that are enrolled in Medicare FFS. Refer to the "Medicare cost sharing for members in Medicare HMO" policy for Managed Care members.

This reimbursement policy will maximize cost avoidance efforts by Contractors and provide a reimbursement methodology that provides continuity of care for AHCCCS members.

## II. Definitions

**Cost Sharing:** Refers to AHCCCS Contractors' obligation for payment of applicable Medicare FFS coinsurance and deductibles, and copayments.

**Dual Eligible:** Refers to an AHCCCS member who is eligible for both Medicaid and Medicare services. There are two types of dual eligible members: those eligible for Qualified Medicare Beneficiary (QMB) benefits (QMB Dual), and Medicare beneficiaries not eligible for QMB benefits (Non-QMB Dual).

**QMB Dual:** An individual who is eligible for QMB benefits as well as Medicaid benefits. QMB duals are entitled to AHCCCS and Medicare Part A and B services.

**Non-QMB Dual:** An individual who is eligible for Medicaid and has Medicare coverage, but who is not eligible for QMB.

**In-Network Provider:** A provider that is contracted with the Contractor to provide services. However, at its discretion, a Contractor may authorize services to be provided by a non-contracted provider, such as a hospital.

**Out of Network Provider:** An out of network provider is a provider that is neither contracted with nor authorized by the Contractor to provide services to AHCCCS members.

**Medicare Risk HMO:** A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries.

## III. Policy

### A. Covered Services

#### 1. QMB Duals

QMB Duals are entitled to all AHCCCS and Medicare part A and B covered services. The Contractor is responsible for the payment of the Medicare deductible and coinsurance for AHCCCS covered services. In addition to AHCCCS covered services, QMB Duals may receive Medicare services that are not covered by AHCCCS, or differ in scope or duration. The services must be provided regardless of whether the provider is in the Contractor's network. These services include:

- Chiropractic services for adults
- Inpatient and outpatient occupational therapy coverage for adults
- Inpatient psychiatric services (Medicare has a lifetime benefit maximum)
- Other behavioral health services such as partial hospitalization
- Any services covered by or added to the Medicare program not covered by AHCCCS

Please refer to the AHCCCS Medical Policy Manual (AMPM) for Medicare only covered services that are specific to the acute care and ALTCS programs.

#### 2. Non- QMB Duals

The Contractor is responsible for the payment of the Medicare deductible and coinsurance for AHCCCS covered services that are rendered on a FFS basis by a Medicare provider within the Contractor’s network. Contractors are not responsible for the services listed in III. A. 1.

### 3. Cost Sharing Matrix

| Covered Services | Contractor Responsibility | In Network | Out of Network* | Prior Authorization Required |
|---|---|---|---|---|
| Medicare Only—not covered by AHCCCS | Cost sharing responsibility only for QMB Duals | YES | YES | NO |
| AHCCCS Only—not covered by Medicare, including pharmacy and other prescribed services | Reimbursement for all medically necessary services | YES | NO | YES |
| AHCCCS and Medicare covered Service (except for emergent) | Cost sharing responsibility only | YES | NO | YES |
| Emergency Services | Cost sharing responsibility only | YES | YES | NO |

*Unless authorized by the AHCCCS Contractor

## B. Limits on Cost Sharing

Contractors have cost sharing responsibility for AHCCCS covered services provided to members by an in-network FFS Medicare provider. Contractors shall have no cost sharing obligation if the Medicare payment exceeds the Contractor's contracted rate for the services. The Contractor's liability for cost sharing plus the amount of Medicare's payment shall not exceed the Contractor's contracted rate for the service.

For those Medicare services for which prior authorization is not required, but are also covered by AHCCCS, there is no cost sharing obligation if the Contractor has a contract with the provider, and the provider's contracted rate includes Medicare cost sharing as specified in the contract.

## C. Prior Authorization

If the Contractor's contract with a provider requires the provider to obtain prior authorization before rendering services, and the provider does not obtain prior authorization, the Contractor is not obligated to pay the Medicare cost sharing for AHCCCS covered services, except for emergent care. The Contractor cannot require prior authorization for Medicare only services.

If the Medicare provider determines that a service is medically necessary, the Contractor is responsible for Medicare cost sharing, even if the Contractor determines otherwise. If Medicare denies a service for lack of medical necessity, the Contractor must apply its own criteria to determine medical necessity. If criteria support medical necessity, then the Contractor shall cover the cost of the service.

## D. Out of Network Services

### 1. Provider

If an out of network referral is made by a contracted provider, and the Contractor specifically prohibits out of network referrals in the provider contract, then the provider may be considered to be in violation of the contract. In this instance, the Contractor has no cost sharing obligation. The provider who referred the member to an out of network provider would be obligated to pay any cost sharing. The member shall not be responsible for the Medicare cost sharing except as stipulated in D.2. of this policy.

### 2. Member

If a member has been advised of the Contractor's network, and the member's responsibility is delineated in the member handbook, and the member elects to go out of network, the member is responsible for paying the Medicare cost sharing amount. (Emergent care, pharmacy, and other prescribed services are the exceptions.) This member responsibility must be explained in the Contractor's member handbook.

## E. Pharmacy and Other Physician Ordered Services

Contractors shall cover prescriptions and other ordered services that are both prescribed and filled by in-network providers. If a provider prescribes a non-formulary prescription, then the Contractor may opt to not reimburse for the prescription. The Contractor may also require prior authorization.

## IV. References

- Social Security Act, 1905(p)(3)
- AHCCCS State Plan Amendment 96-13 - Medicare Cost Sharing
- Arizona Revised Statutes §36-2946 A and §36-2972 C
- Arizona Administrative Code R9-29, Articles 3 and 4

# 202 - MEDICARE COST SHARING FOR MEMBERS IN MEDICARE HMO

Effective Date: 10/01/97
Revision Date: 07/01/03

Staff responsible for policy: DHCM Finance

## I. Purpose

This policy applies to AHCCCS acute care Contractors, Arizona Long Term Care System (ALTCS) Contractors and the Arizona Department of Health Services (ADHS) for Title XIX behavioral health services, hereafter known as Contractors. The purpose of this policy is limited to and defines cost sharing responsibilities of AHCCCS Contractors for their members who are enrolled in Medicare Risk HMO's. Refer to the "Medicare cost sharing for members in Medicare FFS" policy for fee for service members.

This reimbursement policy will maximize cost avoidance efforts by Contractors and provide a reimbursement methodology that provides continuity of care for AHCCCS members.

## II. Definitions

**Cost Sharing:** Refers to AHCCCS Contractors' obligation for payment of applicable Medicare FFS coinsurance and deductibles, and copayments.

**Dual Eligible:** Refers to an AHCCCS member who is eligible for both Medicaid and Medicare services. There are two types of dual eligible members: those eligible for Qualified Medicare Beneficiary (QMB) benefits (QMB Dual), and Medicare beneficiaries not eligible for QMB benefits (Non-QMB Dual).

**QMB Dual:** An individual who is eligible for QMB benefits as well as Medicaid benefits. QMB duals are entitled to AHCCCS and Medicare Part A and B services.

**Non-QMB Dual:** An individual who is eligible for Medicaid and has Medicare coverage, but who is not eligible for QMB.

**In-Network Provider:** A provider that is contracted with the Contractor to provide services. However, at its discretion, a Contractor may authorize services to be provided by a non-contracted provider, such as a hospital.

**Out of Network Provider:** An out of network provider is a provider that is neither contracted with nor authorized by the Contractor to provide services to AHCCCS members.

**Medicare Risk HMO:** A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries.

## III. Policy

### A. Payor of Last Resort

AHCCCS is the payor of last resort. Therefore, if a member is enrolled with a Medicare Risk HMO, the member shall be directed to their Medicare Risk HMO for services. However, if the Medicare Risk HMO does not authorize a Medicaid covered service, the Contractor shall review the requested service for medical necessity, and elect to authorize it.

### B. Covered Services

#### 1. QMB Dual

QMB Duals are entitled to all AHCCCS and Medicare part A and B covered services. In addition to AHCCCS covered services, QMB Duals may receive Medicare services that are not covered by AHCCCS, or differ in scope or duration. When a member is enrolled in a Medicare Risk HMO, the Contractor is responsible for cost sharing for Medicare services that are not covered by AHCCCS, or differ in scope or duration. These services include:

- Chiropractic services for adults
- Inpatient and outpatient occupational therapy coverage for adults
- Inpatient psychiatric services (Medicare has a lifetime benefit maximum)
- Other behavioral health services such as partial hospitalization
- Any services covered by or added to the Medicare program not covered by AHCCCS

Please refer to the AHCCCS Medical Policy Manual (AMPM) for Medicare only covered services that are specific to the acute care and ALTCS programs.

#### 2. Non- QMB Dual

Contractors are responsible for cost sharing for AHCCCS-only covered services for Non-QMBs. Contractors are not responsible for the services listed in III. B. 1.

### 3. Cost Sharing Matrix

| Covered Services— | Contractor Responsibility | In Network | Out of Network* | Prior Authorization Required |
|---|---|---|---|---|
| Medicare Only Covered Services** | Cost Sharing responsibility for QMB Duals Only. | N/A | N/A | NO |
| AHCCCS Only—not covered by Medicare | Reimbursement for all medically necessary services | YES | NO | YES |
| AHCCCS and Medicare covered Service (except for emergent and pharmacy services) | Cost sharing responsibility only | YES | NO | YES |
| Emergency Services | Cost sharing responsibility only | YES | YES | NO |
| Pharmacy and Other Physician Ordered Services (see E. for more details) | Cost sharing responsibility until member reaches HMO cap, then full reimbursement | YES | NO | YES/NO (See E. for more details.) |

*Unless prior authorized. Also, see section E.

****** AHCCCS Contractors are not responsible for cost sharing for Medicare Only Services for Non-QMBs.

### C. Limits on Cost Sharing

Contractors have cost sharing responsibility for all AHCCCS covered services provided to members by a Medicare Risk HMO. For those services that have benefit limits, the Contractor shall reimburse providers for all AHCCCS and Medicare covered services when the member reaches the Medicare Risk HMO's benefit limits.

Contractors only have cost sharing responsibility for the amount of the *member's* coinsurance, deductible or copayment. Total payments to a provider shall not exceed the Medicare allowable amount which includes Medicare's liability and the member's liability. *For* those Medicare services which are also covered by AHCCCS, there is no cost sharing obligation if the Contractor has a contract with the Medicare provider, and the provider's contracted rate includes Medicare cost sharing as specified in the contract.

Contractors shall have no cost sharing obligation if the Medicare payment exceeds the Contractor's contracted rate for the services. The Contractor's liability for cost sharing plus the amount of Medicare's payment shall not exceed the Contractor's contracted rate for the service. With respect to copayments, the Contractor may pay the lesser of the copayment, or their contracted rate.

## D. Prior Authorization

If the Contractor's contract with a provider requires the provider to obtain prior authorization before rendering services, and the provider does not obtain prior authorization, the Contractor is not obligated to pay the Medicare cost sharing for AHCCCS covered services, except for emergent care. See F for exceptions for pharmacy and other physician ordered services.

If the Medicare Risk HMO determines that a service is medically necessary, the Contractor is responsible for Medicare cost sharing, even if the Contractor determines otherwise. If the Medicare Risk HMO denies a service for lack of medical necessity, the Contractor must apply its own criteria to determine medical necessity, and may not use the Medicare Risk HMO's decision as the basis for denial.

## E. Out of Network Services

### 1. Provider

If an out of network referral is made by a contracted provider, and the Contractor specifically prohibits out of network referrals in the provider contract, then the provider may be considered to be in violation of the contract. In this instance, the Contractor has no cost sharing obligation. The provider who referred the member to an out of network provider is obligated to pay any cost sharing. The member shall not be responsible for the Medicare cost sharing except as stipulated in E.2. of this policy.

However, if the Medicare HMO and the Contractor have networks for the same service that have no overlapping providers, and the Contractor chooses not to have the service performed in its own network, then the Contractor is responsible for cost sharing for that service. If the overlapping providers have closed their panels and the member goes to an out of network provider, then the Contractor is responsible for cost sharing.

### 2. Member

If a member has been advised of the Contractor's network, and the member's responsibility is delineated in the member handbook, and the member elects to go out of network, the member is responsible for paying the Medicare cost sharing amount. (Emergent care, pharmacy, and other prescribed services are the exceptions.) This member responsibility must be explained in the Contractor's member handbook.

### F. PHARMACY AND OTHER PHYSICIAN ORDERED SERVICES

Contractors shall cover pharmacy copayments for prescriptions prescribed by both contracted and non-contracted providers as long as the prescriptions are filled at a contracted pharmacy. For purposes of this section, "in network" refers to the provider who supplies the prescription, not the prescribing provider. However, if a provider prescribes a non-formulary prescription, then the Contractor may opt to not reimburse for the prescription copayment. If a Contractor requires prior authorization for formulary medications, then the Contractor may choose not to cover the copayment if prior authorization is not obtained.

If a member exceeds their pharmacy benefit limit, the Contractor shall cover all prescription costs for the member. These prescriptions are subject to the Contractor's formulary, prior authorization and pharmacy network requirements.

If the Medicare Risk HMO does not offer a pharmacy benefit, then the Contractor may require that the prescribing physician be in the Contractor's network for prescription benefit coverage.

This requirement extends to all "prescribed services" such as laboratory and DME.

## IV. References

- Social Security Act, 1905(p)(3)
- AHCCCS State Plan Amendment 96-13 - Medicare Cost Sharing
- Arizona Revised Statutes §36-2946 A and §36-2972 C
- Arizona Administrative Code R9-29, Articles 3 and 4

# 203 – CONTRACTOR CLAIMS PROCESSING BY SUBCONTRACTED PROVIDERS

Effective Date: 02/01/97
Revision Date: 11/01/02, 6/15/05

Staff responsible for policy: DHCM Finance

## I. Purpose

This policy applies to all Contractors with subcontracts that require claims and encounters to be adjudicated and paid by or under the direction of a subcontracted provider group.

Per the AHCCCS contract Section D, Subcontracts, "No subcontract shall operate to terminate the legal responsibility of the Contractor to assure that all activities carried out by the subcontractor conform to the provisions of this contract". Accordingly, AHCCCS holds its Contractors responsible for the complete, accurate, and timely payment of all valid provider claims arising from the provision of medically necessary covered services to its enrolled members regardless of subcontract arrangements.

## II. Definitions

**ACOM:** AHCCCS Contractor Operation Manual

**Subcontracted Provider Group:** Any health plan subcontracted provider, provider group, or provider management company responsible for the coordination of health care service delivery to AHCCCS members.

## III. Policy

A. Contractors shall obtain prior approval from AHCCCS of all subcontracts that call for claims processing to be performed by or under the direction of a subcontracted provider group. The subcontract shall be submitted to AHCCCS Division of Health Care Management for prior approval at least 30 days prior to the beginning date of the subcontract.

B. The Contractor shall ensure they have a mechanism in place to inform providers of the appropriate place to send claims at the time of notification or prior authorization if the provider has not otherwise been informed of such information via subcontract and/or a provider manual.

C. Date of Receipt: The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the

Contractor's specified mailing address. The Contractor shall forward all claims received to the subcontracted provider group responsible for claims adjudication.

D. Timeliness of Claim Submission and Payment: Unless a subcontract specifies otherwise, Contractors with 50,000 or more members shall ensure that 95% of all clean claims are paid within 30 days of receipt of the clean claim and 99% are paid within 60 days of receipt of the clean claim. Unless a subcontract specifies otherwise, Contractors with fewer than 50,000 members shall ensure that 90% of all clean claims are paid within 30 days of receipt of the clean claim and 99% are paid within 60 days of receipt of the clean claim. Additionally, unless a shorter time period is specified in contract, the Contractor shall not pay a claim initially submitted more than 6 months after date of service or pay a clean claim submitted more than 12 months after date of service. Claim payment requirements pertain to both contracted and non-contracted providers.

E. Interest Payments: Effective for all non-hospital clean claims with dates of service October 1, 2004 and thereafter, in the absence of a contract specifying other late payment terms, Contractors are required to pay interest on late payments. Late claims payments are those that are paid after 45 days of receipt of the clean claim (as defined in this contract). In grievance situations, interest shall be paid back to the date interest would have started to accrue beyond the applicable 45 day requirement. Interest shall be at the rate of ten per cent per annum, unless a different rate is stated in a written contract. In the absence of interest payment terms in a subcontract, interest shall accrue starting on the first day after a clean claim is contracted to be paid. For hospital clean claims, a slow payment penalty shall be paid according to R9-22-712(C).

F. Electronic Processing Requirements: Contractors are required to accept HIPAA compliant electronic claims transactions from any provider interested and capable of electronic submission; and must be able to make claims payments via electronic funds transfer. (See Section D, Paragraph 38 for requirements)

G. The Contractor shall require the subcontracted provider group to submit a monthly claims aging summary to the Contractor to ensure compliance with claims payment timeliness standards. The Contractor may consider requiring such reports to be consistent in format with the AHCCCS required reports.

H. The Contractor shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule. The schedule for review shall be submitted to AHCCCSA, Division of Health Care Management for prior approval. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a corrective action plan. The results of the performance review and the correction plan shall be communicated to AHCCCS upon completion.

I. The Contractor shall monitor the volume of encounters received from the subcontracted provider group so that encounters are forwarded in accordance with AHCCCSA's standards and thresholds.

J. The Contractor shall ensure the subcontracted provider group's remittance advice meets the requirements in the AHCCCS RFP including, but not limited to:

1. The remittance advice shall contain sufficient detail to explain the payment including the composition of the net amount of the payment. In addition, if payment is being denied, there must be sufficient detail to explain the reasons for denial.

2. Provider claims dispute rights shall be referenced.

K. The Subcontractor shall adhere to the Coordination of Benefits/Third Party Liability requirements per the RFP, Section D. The Subcontractor shall adhere to all requirements per the ACOM *Member Notice for Non-Covered Services Policy.*

L. The Subcontractor shall adhere to all Health Insurance, Portability and Accountability Act (HIPAA) requirements according to Public Law 107-191, 110 Statutes 1936.

## IV. References

- Acute Care Contract, Section D, Subcontracts, Claims Payment/HealthInformation System, Coordination of Benefits/Third Party Liability

- ALTCS Contract, Section D, Subcontracts, Claims Payment/HealthInformation System, Coordination of Benefits/Third Party Liability

- Arizona Administrative Code R9-22, Article 7: Payments by Contractors

# 204 – TEACHING PHYSICIAN REIMBURSEMENT OPTION

Effective Date: 01/01/2005
Revision Date:

Staff responsible for policy: DHCM Administration

## I. Purpose

This policy applies to AHCCCS Acute and Long Term Care Contractors. This policy describes permissible claiming scenarios for teaching physicians in situations where residents perform specific low level evaluation and management services without the presence of a teaching physician. Contractors may exercise their own judgment in determining whether they will choose this option for their contracted residency programs. When Contractors do utilize this option, documentation of the arrangement must be included in the contract files.

## II. Definitions

For purposes of this policy the following definitions apply:

**Resident:** An individual who participates in an approved Graduate Medical Education (GME) program.

**Teaching Physician:** A physician (other than another resident) who involves residents in the care of his or her patients.

## III. Policy

### A. Hospital outpatient department or other ambulatory entity

1. Consistent with Medicare, AHCCCS permits an exception to the direct supervision rule for certain primary care residency programs. The exception rule allows specific low level evaluation and management CPT codes to be billed by the teaching physician for services rendered by the residents without the presence of the teaching physician. The permitted codes are:

| New Member | Established Member |
|---|---|
| 99201 | 99211 |
| 99202 | 99212 |
| 99203 | 99213 |

Additionally, AHCCCSA allows the inclusion of Preventive Medicine CPT codes 99381 through 99397. All the codes should be used with a "GE" modifier to designate the claim as a teaching physician billing exception claim.

2. For the above exceptions to apply, the residency program must attest to the Contractor in writing that the following conditions are met:

   a. Services must be furnished in an outpatient department of a hospital or other ambulatory entity included in determining GME payments to a teaching hospital.
   b. Residents furnishing service without the presence of a teaching physician must have completed more than **six months** (post graduate) of an approved residency program.
   c. The teaching physician in whose name payment is sought may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability.
   d. The members seen must be an identifiable group of individuals who consider the setting and residency program to be the continuing source of their health care. The residents must generally follow the same group of members through the course of their residency program.
   e. The range of services furnished by the residents includes all of the following: acute and chronic care, care coordination, and comprehensive care not limited by organ system or diagnosis.
   f. The types of residency programs most likely to qualify for the primary care exception rule include: family practice, general internal medicine, geriatric medicine, pediatrics and obstetrics/gynecology.

**Note:** This is an abbreviated summary. Refer to Medicare Part B News, Issue #192 October 22, 2001, "Supervising Physicians in Teaching Settings" for the complete details.

3. Contractors should instruct the teaching physicians to follow the documentation guidelines as outlined by Noridian, the Medicare intermediary in Arizona, in Transmittal 1780, CR 2290, effective November 22, 2002 which describes clarification to "Supervising Physicians in Teaching Settings - Documentation."

**B. Nursing Facility Setting**

1. AHCCCSA permits the billing of the following low level evaluation and management nursing facility CPT codes by the teaching physician for services rendered by the residents without the presence of the teaching physician:

| New Member | Established Member |
|---|---|
| 99301 | 99311 |

All the codes should be used with a "GE" modifier to designate the claim as a teaching physician billing exception claim.

2. For the above to apply, the residency program must attest to the Contractor in writing that the following conditions are met:

    a. Services must be furnished in a nursing facility.
    b. Residents furnishing service without the presence of a teaching physician must have completed more than **twelve months** (post graduate) of an approved residency program.
    c. The teaching physician in whose name payment is sought may not supervise more than four residents at any given time and must be immediately available via telephone.
    d. The members seen must be an identifiable group of individuals who consider the setting and residency program to be the continuing source of their health care. The residents must generally follow the same group of members through the course of their residency program.
    e. The range of services furnished by the residents includes all of the following: acute and chronic, care coordination, and comprehensive care not limited by organ system or diagnosis.
    f. The types of residency programs most likely to qualify include: family practice, general internal medicine, geriatric medicine, pediatrics and obstetrics/gynecology.

3. Contractors should instruct the teaching physicians to follow the documentation guidelines as outlined by Noridian, the Medicare intermediary in Arizona, in Transmittal 1780, CR 2290, effective November 22, 2002 which describes clarification to "Supervising Physicians in Teaching Settings - Documentation."

## IV. References

- Title 42 of the Code of Federal Regulations (42 CFR) 415.152 (Definitions)
- 42 CFR 415.170, 172, 174 (Conditions for Payment for Ambulatory Care)
- Medicare Part B News, Issue #192 October 22, 2001, "Supervising Physicians in Teaching Settings"
- Documentation clarification via Noridian: Transmittal 1780; CR 2290, November 22, 2002, Medicare Part B: "Supervising Physicians in Teaching Settings - Documentation"

## CHAPTER 300 – FINANCIAL PAGE

# 301 - TITLE XIX WAIVER RECONCILIATION POLICY

Effective Date: 10/01/01
Revision Date: 6/15/05, 10/01/04, 10/01/03

Staff responsible for policy: DHCM Finance

## I. Purpose

This policy applies to all AHCCCS Acute Care Contractors (hereafter referred to as Contractors) contracted to provide medical services for the Title XIX Waiver Group (TWG) population.

Due to the programmatic change and the uncertainty regarding actual utilization and medical cost experience of the TWG population, AHCCCS intends to limit the financial risk to its Contractors. The policy defines the elements of the reconciliation.

For CYE '02 and CYE '03, AHCCCS will reimburse 100% of a Contractor's reasonable costs in excess of the Contractor's elected risk band percentage as determined by reported encounter data and subcapitated expense reports. AHCCCS will recoup from any Contractor, profit amounts in excess of the Contractor's elected risk band.

For contract years CYE '04 and CYE '05, AHCCCS will reimburse/recoup 100% of a Contractor's reasonable costs in excess of a 2% profit or loss, as determined by reported encounter data and subcapitated expense reports.

## II. Definitions

**Hospitalized Supplement Payment:** Targeted reimbursement paid to a Contractor for a member who is hospitalized on the date of application.

**PPC Capitation:** Capitation payment for the period of time from the 1st day of the month of application or the 1st eligible month, whichever is later, to the day a member is enrolled with the Contractor. Also, the period of time between the date a MED member was approved and the date the member met spend down, or 1st day of the month the member reduced resources whichever is later.

**Prospective Capitation:** Capitation payments for member months during a member's prospective enrollment with a Contractor. Prospective enrollment is from the date of eligibility determination to the date a member is determined no longer eligible.

**Risk Band:** Percentage of risk to the Contractor. Profits and losses in excess of the elected percentages will either be recouped or reimbursed by AHCCCS in the reconciliation.

**Title XIX Waiver Group Member (TWG):** All Medical Expense Deduction (MED) members, and adults or childless couples at or below 100% of the Federal Poverty Level (Non-MED) who are not categorically linked to another Title XIX program.

## III. Policy

### A. General

1. The reconciliation shall relate to PPC and prospective reported medical expenses net of reinsurance for the TWG population. Administrative, premium tax and non-operating expenses shall be excluded. The amount of the reimbursement to be reconciled against will be *net of the administrative and premium tax components included in the capitation rate (see Attachment A for calculation). The reconciliation shall include all revenue and expenses with eligibility within the contract year.

2. For the contract years CYE '02 and CYE '03, AHCCCS will limit the financial risk to its Contractors. This reconciliation limits the Contractor's losses to 2% and profits to 4% of the Contractor's net TWG capitation. Any losses in excess of 2% will be reimbursed to the Contractor, and likewise, profits in excess of 4% will be recouped. The Contractor may choose to elect an alternative risk sharing methodology to have AHCCCS recoup profits in excess of 1% and reimburse losses in excess of 1%.

3. For contract years CYE '04 and CYE '05, the reconciliation will limit the Contractor's profits and losses to 2% of the Contractor's net TWG capitation. Any losses in excess of 2% will be reimbursed to the Contractor, and likewise, profits in excess of 2% will be recouped.

### B. AHCCCS Responsibilities

1. Approximately six months after the contract year to be reconciled, AHCCCS shall perform an interim reconciliation of actual medical cost experience to capitation and reinsurance paid in order to monitor the status of the risk sharing arrangement:

   PPC Capitation + Prospective Capitation + Hospital Supplement Payment + Maternity Supplement payment + HIV/AIDS payment - administration % - premium tax % (see Attachment A for calculation)

   Less: Total medical expenses (net of reinsurance)

Equals: Profit/Loss to be reconciled according to risk band elections

2. AHCCCS will utilize encounters and subcapitated expenses reported by the Contractor to determine the medical expenses reported.

3. AHCCCS will compare encounter and subcapitated expense information to financial statements for reasonableness.

4. Distributions will be made to the Contractor after the Contractor has agreed to the reconciliation amount.

5. In the event a Contractor is required to reimburse AHCCCS, such reimbursement will be collected by AHCCCS through a reduction to the Contractor's prospective capitation payments upon issuance of the second and final reconciliation.

6. A second and final reconciliation will be done approximately 15 months after the end of the contract year to be reconciled. This will allow for completion of the claims lag and encounter reporting. Any amount over or underpaid as a result of the initial reconciliation will be recouped or reimbursed, respectively, at this time.

7. AHCCCS may perform an audit of self-reported subcapitated expenses included in the reconciliation.

### C. Contractor Responsibilities

1. Contractor shall maintain financial statements that separately identify Title XIX Waiver Group transactions, and shall submit such statements as required by contract and in the format specified in the Reporting Guide.

2. It is the Contractor's responsibility to ensure that all encounters and adjustments have been submitted and accepted by AHCCCS prior to 15 months after the contract year end.

3. Submit data as requested by AHCCCS for reconciliation purposes. (e.g. encounter detail file, reinsurance payments, etc.)

4. Contractor shall report all subcapitated expenses in a format approved by AHCCCS.

## IV. References

- Acute Care Request for Proposal, Section D, Compensation

## V. Note

* Administration percentage by contract year:
  - CYE ’02 – 10%
  - CYE ’03 – 10%
  - CYE ’04 – 9%
  - CYE ’05 – 9%

* Premium tax – 2%

* Attachment A – Sample TWG Reconciliation

# Health Plan
## Title XIX Waiver Group Reconciliation - EXAMPLE
## For Contract Year Ended 9/30/04

| | Non-Med | MED | TOTAL |
|---|---|---|---|
| **Gross TWG Revenue (1)** | $ 130,000,000.00 | $ 26,500,000.00 | $ 156,500,000.00 |
| **Premium Tax** | $ (2,598,980.79) | $ (529,792.24) | $ (3,128,773.03) |
| **Admin %** | $ (10,519,350.21) | $ (2,144,329.08) | $ (12,663,679.29) |
| **TWG Revenue Net of Admin and Premium Tax*** | $ 116,881,669.00 | $ 23,825,878.68 | $ 140,707,547.68 |
| **HP Paid Encounters (2)** | $ (129,886,000.00) | $ (26,800,000.00) | $ (156,686,000.00) |
| **HP Reported Subcapitated Expenditures (3)** | $ (2,518,000.00) | $ (105,000.00) | $ (2,623,000.00) |
| **Exclusion of Subcap Code 01 Encounters (6)** | $ 5,108,000.00 | $ 548,000.00 | $ 5,656,000.00 |
| **Reinsurance Paid (4)** | $ 9,462,000.00 | $ 3,225,000.00 | $ 12,687,000.00 |
| **Net Profit/(Loss)** | $ (952,331.00) | $ 693,878.68 | $ (258,452.32) |
| **% of Rev Net of Admin** | -0.81% | 2.91% | -0.18% |
| **MM (5)** | 380,000 | 60,000 | 440,000 |

| | |
|---|---|
| **Net Capitation** | $ 140,707,547.68 |
| **Total Profit/(Loss)** | $ (258,452.32) |
| **Risk Band Corridor - 2% or (2%)** | $ (2,814,150.95) |
| **CYE 04 TWG Amount Due To (From) Health Plan** | $ - |

**Assumptions:**

**(1) Gross TWG includes all reimbursement paid for the period 10/1/03 - 9/30/04.**

**(2) Health Plan Encounters includes all encounters submitted for the period 10/1/03 - 9/30/04.**

**(3) Subcapitated Expenditures is data submitted by the Health Plans.**

**(4) Reinsurance Paid includes all payments to the Health Plan for the period of 10/1/03 - 9/30/04.**

**(5) Member Months are actual member months paid for the period of 10/1/03-9/30/04.**

**(6) Subcap Code 01 Encounters have been excluded from the data because the health plans are required to self report sub-capitated expenses as noted in #3 above. Subcap Code 01 Encounters for the period of 10/1/03 - 9/30/04.**

Source: TWG Cap and MM Paid - DOS, ReportAHAHG296
TWG Medical Expenses - DOS, Report AHAHG294
Health Plan Self Reported Subcapitated Expenses
TWG Reinsurance Paid from DBF

**Health Plan**
**Title XIX Waiver Group Reconciliation - EXAMPLE**
**For Contract Year Ended 9/30/04**

| *** Building the Gross Capitation Rate** | | |
|---|---|---|
| Cap Rate before Admin and Prem Tax | | $100.00 |
| Add Admin of 9% | +$100 * 9% | $9.00 |
| Subtotal | +$100 + $9 | $109.00 |
| Add Premium Tax (PT) of 2.04% | +$109 * 2.04% | $2.22 |
| Gross Capitation Rate | +$109 + $2.22 | $111.22 |
| | | |
| *** Calculating the Net Revenue** | | |
| Gross Capitation Rate | | $111.22 |
| Deduct Premium Tax (Gross - (Gross/1.0204)) | | $2.22 |
| Deduct Admin ((Gross-PT) - ((Gross-PT)/1.09)) | | $9.00 |
| Net Capitation Revenue (Gross-PT-Admin) | | $100.00 |

Source: TWG Cap and MM Paid - DOS, ReportAHAHG296
TWG Medical Expenses - DOS, Report AHAHG294
Health Plan Self Reported Subcapitated Expenses
TWG Reinsurance Paid from DBF

# 302 - PRIOR PERIOD COVERAGE RECONCILIATION: ACUTE CARE CONTRACTORS

Effective Date: 04/01/98
Revision Date: 6/15/05, 10/01/04, 10/01/03

Staff responsible for policy: DHCM Finance

## I. Purpose

This policy applies to all AHCCCS Acute Care Contractors.

Due to the uncertainty regarding actual utilization and medical cost experience during the PPC period, AHCCCS intends to limit the financial risk to its Contractors. AHCCCS will reconcile the PPC period for all risk groups, except the Title XIX Waiver Group, Title XXI members and SOBRA Family Planning.

For contract years CYE '04 and forward, AHCCCS will reimburse/recoup 100% of a Contractor's reasonable costs in excess of a 2% profit or loss, as determined by reported encounter data. The full PPC period is eligible for this reconciliation.

## II. Definitions

**PPC Period:** The period from the effective date of eligibility to the day a member is enrolled with a Contractor.

**PPC Medical Expense:** Total Medical Expenses for services provided during the PPC time period

## III. Policy

### A. General

1. The reconciliation shall relate solely to aggregate reported PPC medical expenses for the following capitation risk groups: TANF, SOBRA, SSI w/Med and SSI w/o Med. Administrative, premium tax and non-operating expenses shall be excluded. The reconciliation will exclude the Title XIX Waiver Group, and will not relate to Title XXI and SOBRA Family Planning members as they only have prospective enrollment.

2. The reconciliation will limit the Contractor's profits and losses to 2% of the Contractor's net PPC capitation. Any losses in excess of 2% will be reimbursed to the Contractor, and likewise, profits in excess of 2% will be recouped.

## B. AHCCCS Responsibilities

1. Approximately six months after the contract year to be reconciled, AHCCCS shall perform an interim reconciliation of actual medical cost experience to capitation in order to monitor the status of the risk sharing arrangement.

2. The reconciliation for the PPC period shall be based on encounters reported by the Contractor for PPC medical expenses, compared to PPC capitation less administrative and premium tax components paid to the Contractor during the reconciliation year (see Attachment A for calculation):

3. AHCCCS will compare encounter information to financial statements for reasonableness.

4. Distributions will be made to the Contractor after the Contractor has agreed to the reconciliation amount.

5. In the event a Contractor is required to reimburse AHCCCS, such reimbursement will be collected by AHCCCS through a reduction to the Contractor's prospective capitation payments upon issuance of the second and final reconciliation.

6. A final reconciliation will be done approximately 15 months after the end of the contract year to be reconciled. This will allow for completion of the claims lag and encounter reporting. Any amount over or underpaid as a result of the initial reconciliation will be recouped or reimbursed, respectively, at this time.

## C. Contractor Responsibilities

1. Contractor shall maintain financial statements that separately identify all PPC transactions, and shall submit such statements as required by contract and in the format specified in the Reporting Guide.

2. It is the Contractor's responsibility to ensure that all encounters and adjustments have been submitted and accepted by AHCCCS prior to 15 months after the contract year end.

3. Submit data as requested by AHCCCS for reconciliation purposes. (e.g. encounter detail file, reinsurance payments, etc.)

## IV. References

Acute Care Request for Proposal, Section D, Compensation

## V. Note

Administration percentage by contract year:

- CYE '04 – 9%
- CYE '05 – 9%
- CYE '06 – 9%

Premium tax – 2%

Attachment A – Sample PPC Reconciliation

**CONFIDENTIAL**

Attachement A

**HEALTH PLAN**
**PRIOR PERIOD COVERAGE RECONCILIATION - EXAMPLE**
**FOR CONTRACT YEAR ENDED 9/30/04**

| PPC | TANF <1 | TANF 1-13 | TANF 14-44F | TANF 14-44M | TANF 45+ | SSI/W | SSI W/O | COBRA MOTHERS | TOTAL |
|---|---|---|---|---|---|---|---|---|---|
| **PPC Revenue** | $ 315,000.00 | $ 100,000.00 | $ 308,000.00 | $ 80,000.00 | $ 40,000.00 | $ 4,000.00 | $ 15,000.00 | $ 75,000.00 | $ 937,000.00 |
| **Premium Tax** | $ (6,297.53) | $ (1,999.22) | $ (6,157.59) | $ (1,599.37) | $ (799.69) | $ (79.97) | $ (299.88) | $ (1,499.41) | $ (18,732.65) |
| **Admin %** | $ (25,489.19) | $ (8,091.81) | $ (24,922.77) | $ (6,473.45) | $ (3,236.72) | $ (323.67) | $ (1,213.77) | $ (6,068.86) | $ (75,820.24) |
| **PPC Revenue Net of Admin and Premium Ta** | $ 283,213.27 | $ 89,908.98 | $ 276,919.65 | $ 71,927.18 | $ 35,963.59 | $ 3,596.36 | $ 13,486.35 | $ 67,431.73 | $ 842,447.11 |
| **Expenditures HP Paid** | $ (275,000.00) | $ (90,000.00) | $ (280,000.00) | $ (74,000.00) | $ (37,000.00) | $ (4,500.00) | $ (16,000.00) | $ (65,000.00) | $ (841,500.00) |
| **Net Profit/(Loss)** | $ 8,213.27 | $ (91.02) | $ (3,080.35) | $ (2,072.82) | $ (1,036.41) | $ (903.64) | $ (2,513.65) | $ 2,431.73 | $ 947.11 |
| **% of Rev Net of Admin** | 2.90% | -0.10% | -1.11% | -2.88% | -2.88% | -25.13% | -18.64% | 3.61% | 0.11% |

| | |
|---|---|
| **Net Capitation** | $ 842,447.11 |
| **Total Profit/(Loss)** | $ 947.11 |
| **Risk Band Corridor - 2% or (2%)** | $ 16,848.94 |
| **Plan** | $ - |

**Assumptions:**

1) The Title XIX Waiver Group is not included in this reconciliation.
2) PPC Revenue includes PPC Capitation Paid 10/1/03-9/30/04
3) PPC Expenditures include encounters for the period 10/1/03-9/30/04
4) Reinsurance Paid includes all reinsurance amounts paid for the Contract Year Ended 9/30/04

Source:Capitation Payments and Member Months Paid IM02M998B
Reinsurance PPC Recon Summary Report IM02S822
Reconciliation of PPC Expenditures IM010R232

| *** Building the Gross Capitation Rate** | | |
|---|---|---|
| Cap Rate before Admin and Prem Tax | | $100.00 |
| Add Admin of 9% | +$100 * 9% | $9.00 |
| Subtotal | +$100 + $9 | $109.00 |
| Add Premium Tax (PT) of 2.04% | +$109 * 2.04% | $2.22 |
| Gross Capitation Rate | +$109 + $2.22 | $111.22 |

| *** Calculating the Net Revenue** | |
|---|---|
| Gross Capitation Rate | $111.22 |
| Deduct Premium Tax (Gross - (Gross/1.0204)) | $2.22 |
| Deduct Admin ((Gross-PT) - ((Gross-PT)/1.09)) | $9.00 |
| Net Capitation Revenue (Gross-PT-Admin) | $100.00 |

Source:Capitation Payments and Member Months Paid IM02M998B
Reinsurance PPC Recon Summary Report IM02S822
Reconciliation of PPC Expenditures IM010R232

# 303 - CONTRACTOR HIV/AIDS SUPPLEMENTAL PAYMENTS

Effective Date: 04/01/97
Revision Date: 11/01/02, 6/15/05

Staff responsible for policy: DHCM Finance

## I. Purpose

This policy applies to Acute Care and Arizona Long Term Care System (ALTCS) Contractors. This policy outlines the procedures necessary to generate the HIV/AIDS supplemental payment for Contractor members on approved HIV/AIDS drugs.

Per ALTCS Contract, Section D, Compensation, and the Acute Care Contract, Section D, Compensation, HIV/AIDS Supplement, "In addition to the capitation payment…, a separate and additional payment will be made to the Contractor to help defray costs for members receiving approved HIV/AIDS drugs and associated lab work related to their treatment for HIV/AIDS."

On a quarterly basis, the Contractor shall submit to AHCCCSA, Division of Health Care Management (DHCM), an unduplicated monthly count of members, by rate code, who are using approved HIV/AIDS drugs. The report shall be submitted, along with the quarterly financial reporting package, within 60 days after the end of each quarter.

The rate for reimbursement for the payment will be specified in the contract and is subject to review during the term of the contract. Payment will be made quarterly to the Contractor based on the reported members for the quarter, plus/minus any adjustments for previous quarters. AHCCCS reserves the right to recoup any amounts paid for ineligible members as determined as well as an associated penalty for incorrect reporting.

Due to the strict confidentiality of HIV/AIDS patient records, care must be taken when conducting these procedures to preserve confidentiality of member identity.

## II. Definitions

**Member (for purposes of this policy):** A person who is eligible for AHCCCS who is enrolled with a Contractor for not less than 15 days during the reporting month.

**Quarterly HIV-Supplemental Payment Report:** Quarterly information reporting form used to calculate supplemental payments to Contractors to defray the costs for members receiving approved HIV/AIDS drugs for the treatment of HIV/AIDS.

**HIV/AIDS Supplement:** A separate and additional payment made to Contractors to help defray the costs for members receiving approved HIV/AIDS drugs.

**Accuracy:** The reports shall be prepared in strict conformity with AHCCCS defined standards.

**Completeness:** All required information shall be fully disclosed in a manner that is both responsive and pertinent to the report intent with no material omissions. All reports shall be completed in compliance with the instructions outlined on the report.

**HIV/AIDS Drugs:** Antiretroviral agents used to treat HIV/AIDS.

**HIV/AIDS:** Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome.

**Pharmacy Log:** A detailed listing of approved HIV/AIDS prescriptions filled by a pharmacy. The information on the log should include the dates the prescriptions were filled, member's name receiving the prescription, name and dosage of drug. **This log must come from a source independent from the Contractor.**

## III. Policy

### A. Contractor Responsibilities

The Contractors should submit the HIV/AIDS Supplemental Report and pharmacy log with the quarterly reporting package due to the Division of Health Care Management 60 days after the quarter ends. Contractors whose quarters end in months other than March, June, September, and December must report monthly. (See sample of HIV/AIDS Report, Attachment A and pharmacy log, Attachment B)

### B. Adjustments to HIV/AIDS Supplemental Payment Reports

AHCCCS will make payment adjustments to Contractors for members receiving HIV/AIDS drugs for a previous quarter. Contractors are limited to the two prior quarters for requests for additional payments due to an adjustment; however, all adjustments which would reduce the payment made should be submitted, regardless of the length of time involved. An explanation from the Contractor for the adjustment must be submitted along with the revised reports to AHCCCS before a payment related to a previous quarter will be made.

Once the request is submitted, it should be reviewed for reasonableness and approved for payment. The calculation for the payment will be prepared on a separate section of the supplemental payment check request form.

## IV. Sanctions

AHCCCS may assess up to a $5,000 penalty for incorrect reporting per audit period.

## V. Reference

- Acute Care Contract - Section D, Compensation, HIV/AIDS Supplement.
- ALTCS Contract, Section D, Compensation, HIV/AIDS Supplement

**ATTACHMENT A**

# HIV/AIDS Report
# Supplemental Payment Calculation
# For Acute/ALTCS Care Health Plans

**QUARTER ENDING:** _____

| | | # Members on Approved HIV/AIDS Medications & Protease Inhibitors | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |
| Plan Id # | Health Plan | Categorical | | Categorical Linked Expansion | | Non-Categorical | Federal Non-Categorical Linked Expansion NON-MED/MED | Federal Non-Categorical Linked Conversion NON-MED/MED | KidsCare | Subtotal | ALTCS/ DD | | Rate | |
| | | SOBRA/ TANF | SSI | SOBRA/ TANF | SSI | | | | | | | | | |
| 10158 | APIPA | | | | | | | | | 0 | | X | $ 755.46 | = |
| 10533 | CIGNA | | | | | | | | | 0 | | X | $ 755.46 | = |
| 10166 | CMDP | | | | | | | | | 0 | | X | $ 755.46 | = |
| 10254 | CARE 1ST | | | | | | | | | 0 | | X | $ 755.46 | = |
| 10497 | Health Choice | | | | | | | | | 0 | | X | $ 755.46 | = |
| 10083 | Maricopa HP | | | | | | | | | 0 | | X | $ 755.46 | = |
| 10306 | Mercy Care | | | | | | | | | 0 | | X | $ 755.46 | = |
| 10299 | Phoenix Hp | | | | | | | | | 0 | | X | $ 755.46 | = |
| 10124 | Pima Hlth Plan | | | | | | | | | 0 | | X | $ 755.46 | = |
| 10314 | University Family | | | | | | | | | 0 | | X | $ 755.46 | = |
| 110007 | LT DD DES | | | | | | | | | | | X | $ 755.46 | = |
| 110003 | Cochise | | | | | | | | | | | X | $ 755.46 | = |
| 110015 | Pima | | | | | | | | | | | X | $ 755.46 | = |
| 110023 | Maricopa | | | | | | | | | | | X | $ 755.46 | = |
| 110025 | Yavapai | | | | | | | | | | | X | $ 755.46 | = |
| 110049 | Evercare Select | | | | | | | | | | | X | $ 755.46 | = |
| 110306 | Mercy Care | | | | | | | | | | | X | $ 755.46 | = |
| 110065 | Pinal / Gila | | | | | | | | | | | X | $ 755.46 | = |
| | Subtotal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |

| | | Calculated Supplemental Payment due to Contractor | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |
| Plan Id # | Health Plan | Categorical | | Categorical Linked Expansion | | Non-Categorical | Federal Non-Categorical Linked Expansion AC/MED | Federal Non-Categorical Linked Conversion AC/MED | KidsCare | Prior Quarter Adjustment | ALTCS/ DD | TOTAL |
| | | SOBRA/ TANF | SSI | SOBRA/ TANF | SSI | | | | | | | |
| 10158 | APIPA | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 10533 | CIGNA | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 10166 | CMDP | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 10254 | CARE 1ST | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 10497 | Health Choice | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 10083 | Maricopa HP | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 10306 | Mercy Care | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 10299 | Phoenix Hp | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 10124 | Pima Hlth Plan | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 10314 | University Family | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 110007 | LT DD DES | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 110003 | Cochise | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 110015 | Pima | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 110023 | Maricopa | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 110025 | Yavapai | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 110049 | Evercare Select | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 110306 | Mercy Care | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| 110065 | Pinal / Gila | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | | $ - | $ - |
| | Subtotal | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |

Preparer's Name & Signature: _____

Financial Manager's Approval: _____

Date of Checks/Payment Date: _____

Please return a copy of this completed form to DHCM upon completion of payment.

**HIV/AIDS Supplemental Payment Report**
**For Acute Care and Program Contractors**

**ATTACHMENT A-1**

**HEALTH PLAN/ PROGRAM CONTRACTOR:** _____

**QUARTER ENDING:** _____

| MONTH | Categorical | | Categorical Linked Expansion | | Non-Categorical | Federal Non-Categorical Linked Expansion NON-MED/MED | Federal Non-Categorical Linked Conversion NON-MED/MED | KidsCare | ALTCS/ DD | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|
| | SOBRA/ TANF | SSI | SOBRA/ TANF | SSI | | | | | | |
| | | | | | | | | | | 0 |
| | | | | | | | | | | 0 |
| | | | | | | | | | | 0 |
| TOTAL | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

# PHARMACY LOG

# ATTACHMENT B

**Health Plan**
**Listing Of All HIV Medications**
**Pharmacy Log**
Accrual is based on 1 medication per month @ 755.46 for eligible members

| MONTH | Quarter | GROUP | SUBACCOUNT | FQHC Category | Category | GPI | NDC | DRUG NAME | AMT DUE | MBR ID | LAST NAME | FIRST | Full Name | PCP Name | DAYS QTY SUPP | # OF CLAIMS | DATE OF FILL | Month Paid | Drug Coun | Comments | Payment Expected | Payment Rec'd | Received Date | Balance due |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

# 304 – PREMIUM TAX REPORTING

Effective Date: 10/01/03
Revision Date: 6/15/05

Staff responsible for policy: DHCM Finance

## I. Purpose

This policy outlines the procedures necessary for AHCCCS Contractors to report and pay Premium Tax to the Arizona Department of Insurance (DOI) on a quarterly basis.

Under A.R.S. 36-2905 and 36-2944.01, each AHCCCS Contractor is required to pay to the DOI a tax equal to 2% of the total capitation, including reinsurance, and any other reimbursement **paid** to the Contractor by AHCCCS from and after October 1, 2003.

Each Contractor will report and pay premium tax to the DOI for all payments received from AHCCCS during the quarter. The tax is based on date of payment, not date of service. AHCCCS administration will report to the DOI the total payments to each Contractor for the calendar year by February 15th of the following year.

## II. Definitions

**AHCCCS -** Arizona Health Care Cost Containment System

**AHCCCS Contractors -** Acute Care Health Plans, Arizona Long Term Care System Program Contractors, Department of Economic Security/Division of Developmental Disabilities, Children's Rehabilitative Services, Comprehensive Medical Dental Program, and Behavioral Health Services

**BHS –** Behavioral Health Services within the Department of Health Services.

**CMDP** – Comprehensive Medical Dental Program

**Contractor –** Under the definitions in 36-2901, "Contractor" means an entity paid by AHCCCS on a prepaid, capitated basis, which means the entity receives payment notwithstanding the amount of services provided to a member.

**Capitation** – A payment to a Contractor based on a fixed contract rate per member enrolled to receive services of the Contractor. The contractor receives the capitation amount regardless of the cost of services to the member.

**CRS –** Children's Rehabilitative Services

**CYE –** Contract year ending/ended

**DBF -** Division of Business and Finance within AHCCCS

**DDD –** Division for the Developmentally Disabled within the Department of Economic Security.

**DHCM –** Division of Health Care Management within AHCCCS.

**DOI –** Arizona Department of Insurance

**EPD –** Elderly and physically disabled

**FFS –** Fee for service

**HCBS –** Home and Community-based Services

**IGA (InterGovernmenal Agreement) –** An agreement between two state agencies whereby one state agency provides goods and/or services to another.

**Payment –** a payment that is made to the Contractor

**PPC –** Prior-Period Coverage

**Recoupment –** a payment that has been refunded by the Contractor to AHCCCS .

**SOC –** Share of Costs

**TWG –** Title 19 Waiver Group

**VD –** Ventilator Dependent

## III. Policy

A. Quarterly Submission of Premium Tax to DOI

Each AHCCCS Contractor (Attachment A) is required to file a quarterly tax report(Attachment B) and pay estimated premium taxes based on estimated payments received for the current quarter. See Attachment C for information on how payments will be handled. The premium tax is based on date of payment, not date of service. The tax payments are due on or before March 15, June 15, September 15 and December 15 of each year. The amount of the payments shall be an estimate of the tax due for the quarter that ends in the month that payment is due. If a Contractor has no tax to report, the Contractor must file a form stating $0 tax due.

B. Payments include:

- capitation revenue
- delivery and hospital supplements
- reinsurance
- HIV/AIDS supplemental payments
- Reconciliation payments/recoupments (PPC, TWG, HCBS, SOC, Revenue, etc.) – based on a comparison of what was actually paid to the Contractor based on capitation rates excluding the premium tax component against the actual expenses incurred by the Contractor in providing services excluding the premium tax component. If the capitation amount paid to the Contractor does not cover actual expenses, AHCCCS will make a supplemental payment to the Contractor, which is subject to the 2% premium tax. If the capitation amount exceeds the actual expenses incurred by the Contractor in providing services, the Contractor shall be required to refund to AHCCCS the amount by which the capitation amount exceeded actual expenses, which shall reduce the amount subject to the 2% premium tax.
- Monies withheld due to sanction shall not reduce the taxable amount due. These amounts will be added back into the total payments.

C. Payments to Contractors; Inclusion/Exclusion of Premium Tax:

- Any capitation payments/recoupments related to dates of service prior to October 1, 2003, will not have the premium tax included. The Contractor will not be reimbursed for the premium tax associated with these payments. However, the Contractor will be responsible for reporting and paying premium taxes associated with payments/recoupments made after October 1, 2003 (regardless of the dates of service). All capitation rates effective October 1, 2003, include the premium tax in the rate.
- Reconciling payments and supplemental payments will have the premium tax included in the payment.
- Reinsurance payments include the premium tax for all payments/recoupments made after October 1, 2003, regardless of the dates of service. For recoupment of payments made prior to October 1, 2003, the premium tax will not be recouped.

D. Payments Excluded from Premium Tax:

- *Tribal Case Management* – Only receives payment for case management services, and payments are paid on a fee-for-service basis. Additionally, Tribal Case Management only receives payments on behalf of a member for a month in which some case management service is provided to the member. In other words, if no services are provided to a member for a month, they do not receive the monthly case rate for that member. Thus, this is not capitation as defined, and payments are therefore not subject to premium tax.

- *Federally Qualified Health Centers (FQHC)* – Contract with AHCCCS Contractors to provide services to members, and is not itself considered a direct Contractor with AHCCCS that receives capitation from AHCCCS.
- *Health Care Group (HCG)* – HCG is eligible under 36-2901, paragraph 6, subdivision (b), (c), (d) or (e), which is not included within the scope of the legislation.
- *Fee for Service (FFS)* – AHCCCS, DDD – Payments are based on services provided to FFS members
- *Third Party Liability* – If a Contractor pays a claim and finds that there is another party that is responsible for paying the claim, the Contractor or AHCCCS (via Public Consulting Group) will subrogate the claim to the third party and will recover the amount that had been paid from the third party. The recovery of the expense is not subject to premium tax.
- *Fraud and Abuse* – Recovery of overpayment made by a Contractor to a provider. This is considered a contra-expense and is not subject to premium tax.
- *Indian Health Services* – Payments are paid on a fee-for-service basis.
- *Breast & Cervical Cancer Administration Payment* – Payments are in response to billings from the entity for administration services rendered and are not based on member capitation. Therefore, this entity is not considered a Contractor.
- *Premium Sharing Program* – This program ended in the middle of September 2003. Payments under this program were outside the scope of the premium tax legislation.

E. Quarterly Reporting to AHCCCS

In addition to filing the original Form E-QTR, AHCCCS Contractor Quarterly Premium Tax Report, and tax payment with the DOI, each Contractor will submit a copy of the premium tax report(s) filed to:

Finance Manager, DHCM
AHCCCS
701 E. Jefferson, M/D 6100
Phoenix, AZ 85034

The copy of the quarterly premium tax report(s) shall be due on the same date the original of the quarterly premium tax report is due to the DOI. DHCM will then compare the copy to AHCCCS Contractor payment records. AHCCCS will work with the Contractor to research and resolve any significant discrepancies.

Form E-QTR and the accompanying instructions have been revised as of December 2004. Additionally, the Contractor must now submit Form E-QTR Adjustment with the quarterly report when adjustments are made for prior quarters.

F. Annual Reporting to DOI by Division of -Health Care Management (DHCM

No later than January 31 of each year, the Division of Business and Finance (DBF) shall provide a report to DHCM listing all payments AHCCCS made to Contractors for the preceding calendar year. By February 15 succeeding the end of a calendar (tax) year, DHCM will report the total amount AHCCCS paid to Contractors, by health plan to:

Compliance Section Manager, Financial Affairs Division
Arizona Department of Insurance
2910 N. 44th St., Suite 210
Phoenix, AZ 85018-7256

The DOI will compare this information to the quarterly reports submitted by the contractors. The DOI will issue an assessment of additional tax and may impose penalties and interest to a Contractor that underpaid the tax during the preceding calendar year. The penalty may be as much as 5% of the amount of tax paid late, with a minimum penalty of $25. Interest is 1% of the tax paid late per month. The DOI will issue refunds to any Contractor that overpaid the tax for the calendar year period.

DHCM will provide to DBF a summary reconciliation to include any exceptions between the gross and taxable payments for the year.

## IV. Payment Options

A. PAYMENT BY CHECK CAN BE MAILED, DELIVERED BY OVERNIGHT COURIER OR HAND DELIVERED. THE DOI ACCEPTS U.S. POSTAL SERVICE POSTMARK AS EVIDENCE OF FILING. POSTAGE METER STAMPS DO NOT APPLY. FILINGS RECEIVED BY OVERNIGHT COURIER MUST INCLUDE AN AIRBILL OR RECEIPT BEARING THE DATE THAT THE ITEM WAS PICKED UP BY THE COURIER FROM THE ORIGINATING SENDER. HAND DELIVERIES MUST BE RECEIVED BEFORE 5:00 P.M. ON THE DUE DATE.

B. PAYMENT BY ACH MUST POST TO THE DOI'S ACH ACCOUNT ON OR BEFORE THE DUE DATE. SEE FORM E-ACH.INSTRUCTION (ATTACHMENT D) FOR DETAILS ON THE ACH PAYMENT OPTION.

C. Payment is due on or before the due date for filing. When a due date falls on a weekend or a state holiday, it is extended to the following business day.

## V. TIMELINESS

The submission of late reports shall constitute failure to report subject to the Civil Penalty and Interest for Late Tax Payment provisions described in the premium tax reporting instructions. (Attachment B)

## VI. ADJUSTMENTS TO QUARTERLY PREMIUM TAX PAYMENTS

The tax form includes a line to make overpayment or underpayment adjustments to the previous quarter for the first three quarters of the calendar year. Adjustments to the December 15 payment will not be reported on the March 15 tax report. Effective as of calendar year 2005, if an adjustment is made on Form E-QTR for a prior quarter, Form E-QTR Adjustment must also be filled out and submitted with the quarterly form.

The DOI will reconcile all tax payments received to the data provided by AHCCCS before April 1 of the following calendar year and will issue an assessment with a Notice of Right of Appeal if the Contractor has underpaid the tax for the calendar year period.

If a Contractor receives a significant payment from AHCCCS after a tax report is filed but before the end of the tax period, the contractor should promptly file an amended tax report for that period along with documentation supporting the amended filing and additional tax payment.

## VII. Reference

- A.R.S. §§ 36-2905 and 36-2944.01
- Attachment A – List of Contractors
- AttachmentB –Forms E-QTR and E-QTR ADJUSTMENT and accompanying E-QTR.INSTRUCTIONS
- Attachment C – Matrix of Reimbursement for Premium Tax Collection
- Attachment D – Form E-ACH.INSTRUCTION

**LIST OF CONTRACTORS** **Attachment A**

# AHCCCS
## Effective October 1, 2003

| HEALTH PLAN | HP ID # | ACUTE | EPD | VD |
|---|---|---|---|---|
| ARIZONA PHYSICIANS IPA | 010158 | X | | |
| CARE 1ST HEALTHPLAN | 010254 | X | | |
| COCHISE HEALTH SYSTEMS | 110003 | | X | |
| | 550003 | | | X |
| EVERCARE SELECT | 110049 | | X | |
| | 550047 | | | X |
| HEALTH CHOICE ARIZONA | 010497 | X | | |
| MARICOPA INTEGRATED HEALTH SYSTEMS | 010083 | X | | |
| | 110023 | | X | |
| | 550021 | | | X |
| MERCY CARE PLAN | 010306 | X | | |
| | 110306 | | X | |
| | 550306 | | | X |
| PHOENIX HEALTH PLAN | 010299 | X | | |
| COMMUNITY CONNECTION | 010299 | X | | |
| PIMA HEALTH PLAN | 010124 | X | | |
| | 110015 | | X | |
| | 550013 | | | X |
| PINAL/GILA COUNTY LTC | 110065 | | X | |
| | 550063 | | | X |
| UNIVERSITY FAMILY CARE | 010314 | X | | |
| YAVAPAI COUNTY LTC | 110025 | | X | |
| | 550025 | | | X |
| DES/CMDP | 010166 | X | | |
| DES/DDD | 110007 | | X | |
| | 550005 | | | X |
| ADHS/BHS | 079999 | X | | |
| | 079873 | X | | |
| ADHS/CRS | 999111 | X | | |

ARIZONA DEPARTMENT OF INSURANCE
*Financial Affairs Division*
PREMIUM TAX UNIT
2910 NORTH 44TH STREET, SECOND FLOOR
Phoenix, Arizona 85018-7256
Phone: (602) 912-8427/Fax: (602) 912-8421

# 2004 AHCCCS CONTRACTOR QUARTERLY PREMIUM TAX INSTRUCTIONS
## TAX REPORT FORMS INVENTORY AND INSTRUCTIONS

| FORM NAME | FORM DESCRIPTION | DUE DATE |
|---|---|---|
| E-QTR1 | AHCCCS CONTRACTOR Quarterly Premium Tax Report – 1st Quarter | 03/15/04 |
| E-QTR2 | AHCCCS CONTRACTOR Quarterly Premium Tax Report – 2nd Quarter | 06/15/04 |
| E-QTR3 | AHCCCS CONTRACTOR Quarterly Premium Tax Report – 3rd Quarter | 09/15/04 |
| E-QTR4 | AHCCCS CONTRACTOR Quarterly Premium Tax Report - 4th Quarter | 12/15/04 |

WHO MUST FILE: Each AHCCCS Contractor is required to file quarterly tax reports and pay the estimated premium tax pursuant to A.R.S. §§ 36-2905 and 36-2944.01 on or before the Due Dates shown above.

DUE DATE: The Quarterly Premium Tax Reports AND the payment of tax must be filed on or before the Due Date.*

POSTMARK POLICY: This Department honors validation or postmark by the U.S. Postal Service as evidence of filing. POSTAGE METER STAMPS DO NOT APPLY.

OVERNIGHT COURIER OR HAND-DELIVERY: Filings received by overnight courier must include an invoice or receipt bearing the date that the item was picked up by the courier from the originating sender. Hand-deliveries must be received before 5:00 P.M. on the Due Date. *

* When the Due Date falls on Saturday, Sunday or a State-observed holiday it is extended to the next business day.

HOW TO COMPLETE THE QUARTERLY PREMIUM TAX REPORT FORMS: The following information must be provided in each Quarterly Premium Tax Report filed by the Contractor:

1. The PLAN I.D. NUMBER assigned by AHCCCS for each type of plan for which the Contractor provides services under a contract with AHCCCS.
2. ESTIMATED AMOUNTS of the total capitation, including reinsurance and any other reimbursement paid to the Contractor by AHCCCS during the calendar quarter for each Plan Type. Since the tax is due prior to the close of the calendar quarter, the Contractor must reasonably estimate the total amounts for the quarter. To reasonably estimate the total amounts for the quarter, the Contractor should:
   a) Determine the latest date by which it must prepare the tax report to assure timely filing and payment.
   b) Account for all amounts actually paid during the calendar quarter up to the date that the report is prepared.
   c) Determine if recent enrollment activity will generate additional payments to the Contractor from AHCCCS.
3. Computation and payment of Penalty and Interest if tax is paid late.
4. Name and contact information for tax report Preparer.
5. An ADJUSTMENT FOR PREVIOUS QUARTER (not applicable in 2003 and not applicable to 1st Quarter reports) should be entered on Line 8 if a Contractor underpaid its tax for the previous calendar quarter by 10% or more, based on the Estimated Amounts reported and the actual amounts paid to the Contractor by AHCCCS in that quarter. Payments of additional tax for the previous quarter that are made in this manner will not incur penalty or interest. However, an Adjustment to reduce the tax payment for the previous quarter may subject a Contractor to penalty and interest if the total of all tax payments for the year are less than the amount of tax required to be paid according to the records that AHCCCS provides to this Department after December 31, as described below.

CIVIL PENALTY AND INTEREST FOR LATE TAX PAYMENT: A Contractor should compute and pay Penalty and Interest when a tax is paid late, except for the payments made as Adjustment For Previous Quarter described in paragraph 5 above. Each year before April 1st, this Department will reconcile the tax paid by a Contractor to the actual amount of reimbursement paid to the Contractor by AHCCCS in the preceding calendar year. This Department will issue an assessment of additional tax and any applicable penalty and interest with a Notice of Right of Appeal to a Contractor that underpaid the tax for the calendar year period. This Department will issue a refund to a Contractor that overpaid the tax for the calendar year period.

**Attachment C**

# Matrix of Managed Care Contracting and Reimbursement
# Premium Tax Collection
# Effective 10/01/03

| Reimbursement | Acute Care | ALTCS EPD/VD | ALTCS DES/DDD VD | CMDP | ADHS/CRS | ADHS/BHS | Handling of P.T. |
|---|---|---|---|---|---|---|---|
| Prospective Capitation | Yes | Yes | Yes | Yes | Yes | Yes | 1 |
| PPC Capitation | Yes | Yes | No | Yes | No | No | 1 |
| Delivery Supplement | Yes | No | No | No | No | No | 1 |
| Hospitalized Supplement | Yes | No | No | No | No | No | 1 |
| HIV/AIDS Supplemental Payment | Yes | Yes | No | Yes | No | No | 1 |
| DDD/BHS Capitation | No | No | Yes | No | No | No | 5 |
| DES/DDD Reinsurance Capitation | No | No | Yes | No | No | No | 4 |
| Inpatient Reinsurance | Yes | No | No | Yes | No | No | 4 |
| Catastrophic Reinsurance | Yes | Yes | Yes | Yes | No | No | 4 |
| Transplant Reinsurance | Yes | Yes | Yes | Yes | No | No | 4 |
| BH Reinsurance | No | Yes | No | No | No | No | 4 |
| All LTC Services Reinsurance | No | Yes | No | No | No | No | 4 |
| PPC Reconciliation | Yes | Yes | No | Yes | No | No | 2 |
| TWG Reconciliation | Yes | No | No | No | No | No | 2 |
| HCBS Reconciliation | No | Yes | No | No | No | No | 3 |
| SOC Reconciliation | No | Yes | No | No | No | No | 3 |
| Revenue Reconciliation | No | No | No | No | Yes | No | 2 |
| Acute Care Only Reconciliation | No | Yes | No | No | No | No | 1 |
| Profit Risk Band-Corridor | No | No | No | No | No | Yes | 2 |

| Reimbursement | Acute Care | ALTCS EPD/VD | DES/DDD | CMDP | ADHS/CRS | ADHS/BHS | Handling of P.T. |
|---|---|---|---|---|---|---|---|
| Targeted Case Management | No | No | Yes | No | No | No | 2 |
| Ventilator Depend Recon | No | Yes | No | No | No | No | 3 |

Status of how premium tax will be handled:

1. Any capitation payments/recoupments related to date of service prior to October 1, 2003 will not have the 2.04% premium included. The contractor will be responsible for reporting the premium tax. All rates effective 10/1/03 have the 2.04% premium included in rate.

2. The premium tax will be added to the payment manually.

3. ALTCS performs the reconciliation and develops a rate that is used for a mass adjustment. The 2.04% will be included in the rate.

4. Reinsurance will have 2.04% directly included in all payments/recoupments made after 10/1/03. For recoupments of payments made prior to 10/1/03, the premium tax will not be recouped. Tribal and FFS payments will be excluded from Premium Tax.

5. Rate is set for DDD which includes 2.04% premium tax. The component for BHS is paid to BHS, of which the 2.04% is not included. DDD receives the tax that is related to the BHS payment and will be responsible for payment.

Payments Not liable for Premium Tax

- Tribal Case Management - ALTCS
- Federally Qualified Health Centers (FQHC)
- Health Care Group (HCG) – no federal participation
- Fee for Service (FFS) – AHCCCS and DDD
- Third Party Liability
- Fraud and Abuse
- Indian Health Services
- Premium Sharing

Payments to be identified outside of Oracle reporting

- Schaller Family Planning Services payments – Add to Mercy Care Plan acute payments
- Fraud and Abuse – Track separately, should not be included in Premium Tax
- Sanctions – Will be tracked by Contracts. Amount withheld must be added to contractor's reimbursement.
- DDD/BHS payments – Add to DDD payments
- CRS Revenue Recon – Annual Recon. Recoup does not go through Oracle
- BHS Profit Risk Band - Annual Recon. Recoup does not go through Oracle

## 305– PERFORMANCE BOND AND EQUITY PER MEMBER REQUIREMENTS

Effective Date: 10/01/03
Revision Date: 06/15/05

Staff responsible for policy: DHCM Finance

### I. Purpose

This policy applies to all AHCCCS contractors that are required to both maintain a performance bond and meet a minimum equity requirement. The purpose of this policy is to establish flexible standards for contractors to meet the performance bonding and equity requirements. These standards will continue to ensure a contractor's ability to meet its claims payment obligations, while addressing the individual differences among contractors and accelerated enrollment growth.

### II. Definitions

Performance Bond: In general, a performance bond is an instrument that provides a financial guarantee in the amount of one month's capitation. Refer to the *AHCCCS Performance Bond Policy* for definitions of acceptable instruments

Equity: Net Assets that are not designated or restricted for specific purposes.

### III. Policy

A. Equity per member requirements:

| | |
|---|---|
| Contractors with 0-99,999 members: | $150 |
| Contractors with 100,000+ members: | $100 |

B. Performance bonding requirements:

The amount of the performance bond for all contractors is 75% of one month's capitation. For purposes of this policy capitation, supplemental payments, and premiums from all lines of AHCCCS business are considered for this calculation. When the amount of the performance bond falls below 70% of one month's capitation, then the amount of the instrument must be increased to at least 80% of one month's capitation. Contractors must increase the amount of the performance bond within 30 days of notice from AHCCCSA.

C. Remediation when a contractor fails to meet the equity per member requirement:

If a contractor's equity per member falls below the requirement, then AHCCCS will review the causes for the lack of compliance. AHCCCSA may require the contractor to comply with the follow measures:

- ✓ Submission of corrective action plan to increase equity
- ✓ Monthly financial reporting
- ✓ Increase the amount of the performance bond
- ✓ Capital infusion to bring equity into compliance

In addition, if the contractor fails to comply with the above requirements, AHCCCSA may apply sanctions as delineated in the *Sanctions Policy*.

D. Restrictions on equity:

The following asset types will constitute restricted, and therefore will be subtracted from a contractor's equity when calculating the equity per member ratio:

1. Assets recorded as "due from affiliates" which are encumbered by the parent company
2. Goodwill resulting from a purchase
3. Guarantees of debt
4. On balance sheet performance bonds
5. Other assets designated as restricted by AHCCCSA

E. Requirements for contractors with restricted equity:

If a contractor's equity is not supported by unrestricted cash or investments, and the contractor does not meet the equity per member requirements, then the contractor may be required to maintain a performance bond in the amount greater than 75% of one month's capitation to cover the amount of the equity necessary to meet the requirements.

**IV. Division of Health Care Management (DHCM) Monitoring Responsibilities**

1. DHCM financial consultants will be responsible for monitoring compliance with performance bond and equity requirements on a quarterly basis. Analyses will be performed to determine the performance bond and equity per member sufficiency. Deficiencies and requests for remediation will be communicated in writing to the contractor. The contractor will be required to submit a plan to increase the equity within 30 days.

2. The financial consultant responsible for performance bonds will continue to monitor compliance with performance bond requirements on a monthly basis. AHCCCS will

notify the contractor, by the 15th day of the month, of required changes to the amount of the performance bond. Contractors will have 30 days to comply with new requirements.

## IV. References

Acute Care contract, Section D, Paragraphs 46, 47, 48, 50
ALTCS contract, Section D, Paragraphs 46, 47, 48 50, and 52

# 306 – PERFORMANCE BOND

Effective Date: 10/01/97
Revision Date: 06/15/05, 07/01/99, 05/01/98

Staff responsible for policy: DHCM Finance

## I. Purpose

This policy applies to all Health Plans and Program Contractors that require a performance bond.

The AHCCCS Request for Proposal (RFP) requires the posting of a Performance Bond (PB), Section D, *Performance Bond or Bond Substitute and Amount of Performance Bond*, as long as the Contractor has AHCCCS-related liabilities of $50,000 or more outstanding, or 15 months following the effective date of their contract, whichever is later, to guarantee (1) payment of the Contractor's obligations to providers and non-contracting providers and (2) performance by the Contractor of its obligations under this Contract.

## II. Definitions

1. United States Treasury Notes & Bonds
   This type of security is backed by the full faith and credit of the United States Government. These are notes with maturities ranging from two to thirty years. Interest is paid semiannually on the anniversary of the issue date and six months later. They are considered coupon securities even though they are now mostly issued in book entry form. Ownership is simply entered in the computers of the Federal Reserve. Interest is paid by the Federal Reserve issuing credits to the member banks that the notes are recorded through, and the banks credit the customer's account.

2. United States Treasury Bill (T-Bills)
   This type of security is backed by the full faith and credit of the United States Government, just like the Notes and Bonds. The only differences are that T-Bills are much shorter in term, three and six months, and they are sold at a discount. This means that less than the face amount is paid at original purchase and the face amount is recovered at maturity. The interest earned is part of the face amount and is earned on the amount paid for the T-Bill.

3. Federal Farm Credit Banks Funding Corporation (FFCB)
   The FFCB is 37 banks that issue two types of securities that can be substituted for the PB, Consolidated Systemwide Bonds and Consolidated Systemwide Notes. The securities are the joint and several obligations of all 37 member banks of the FFCB. It is felt that Congress will not allow this alliance to fail because of the farming community's dependence for funds.

4. Federal Home Loan Banks (FHLB)
The FHLB serves the same function for the Savings and Loan industry as the Federal Reserve for the banking industry. It is owned by the member Savings and Loan and issues coupon bonds much like the Federal Reserve.

5. Federal National Mortgage Association (FNMA)
The securities issued by FNMA are often called "Fannie Mae's". FNMA issues two types of securities, bonds and mortgage bonds. The coupon interest bonds are the securities acceptable for the PB. The mortgage bonds are not acceptable because of the repayment of the principal over the life of the bonds.

6. Federal Home Loan Mortgage Corporation (FHLMC)
The securities issued by FHLMC are often called "Freddie Mac's". Bonds issued by FHLMC are mortgage type bonds that are repaid to principal and interest over the life of the bond, and the mortgages that secure the bond. This causes the principal to draw down over the life of the bond, and the life of the PB.

7. Government National Mortgage Association (GNMA)
The securities issued by GNMA are often called "Ginnie Mae's". Bonds issued by GNMA are mortgage type bonds that are repaid to principal and interest over the life of the bond, and the mortgages that secure the bond. This causes the principal to draw down over the life of the bond, and the life of the PB.

8. Municipal Bonds
Bonds issued by a municipality. The two types are General Obligation Bonds, backed by the full faith and credit of the issuer, and Revenue Bonds, repaid by the revenue generated by the project the bonds fund. Recent bankruptcies of some cities and the fact that most of these bonds are not insured makes repayment of principal somewhat endangered.

9. Corporate Bonds
The most common form of bonds this category represents is debentures. Debentures are bonds drawn on the general credit and good name, of the issuing company. Rating services, Moody and S&P, and reporting companies, Dun and Bradstreet, try to continually assess the bonds value, and their issuing companies, but are limited to historic data. In the case of D&B the rating of America West Airlines was rated as good up to two months before the company filed for bankruptcy protection. This causes most users of the services to become aware of critical situations only after it is to late to do anything. This is another category of securities that is considered a good investment but does not meet the much higher standards that need to be applied in meeting the PB.

10. Commercial Paper
Short-term notes issued by corporations that are much like corporate bonds. The major difference is that commercial paper must be issued for less than 270 days; this allows the corporation to avoid registration of the security. Being like corporate bonds, commercial paper holds the same drawbacks but with no advantages as a PB for AHCCCS. Also,

because these notes are short-term they do not lend themselves to the 15 month time frame required by the PB.

11. Stocks (Equity Investments)
Stocks, even in the most stable credit worthy companies, vary in value every day. This would require a considerable cushion above the required PB amount to compensate for market fluctuations. Also it would require AHCCCS to monitor the value of each stock posted as a PB. This would require the resources normally found only with large investors or brokers. This monitoring is well beyond the intent of the PB.

12. Banker's Acceptance (BA)
Bankers' Acceptance are notes from other than a bank that are guaranteed by the issuing bank. They are short-term in nature, less than 270 days to elude regulation.

13. Mutual Funds
Mutual Funds are an equity ownership in the fund rather than ownership in any of the securities held by the fund. The principal may be in jeopardy of loss through the mutual fund's investment losses or administration expenses. Even when the fund is dominated by or wholly made up of treasury securities the fund's owner does not own the securities.

**III. Policy**

Section D, *Amount of Performance Bond*, requires the initial amount of the Performance Bond to be equal to 80% of the total capitation payment expected to be paid in the first month of the new contract, or as determined by AHCCCS. Thereafter, AHCCCSA shall evaluate the enrollment statistics of the contractor on a monthly basis and determine if adjustments are necessary in accordance with the *Performance Bond and Equity Per Member Policy*.
The following are general requirements for all PB's:

1. The amount, duration or scope of the PB may not be changed or discontinued without prior approval of AHCCCS Division of Health Care Management (DHCM).
2. A contact person must be listed and their phone number.
3. Any security agreement must be disclosed.
4. AHCCCS will confirm the PB with the appropriate institution at least annually.

Listed are several specific ways to satisfy the Performance Bond (PB):

1. Cash Deposits, or
2. An Irrevocable Letter of Credit issued by:
   A. a bank insured by the Federal Deposit Insurance Corporation
   B. a savings and loan association insured by the Federal Savings and Loan Insurance Corporation, or
   C. a credit union insured by the National Credit Union Administration, or
3 Surety Bond issued by a surety or insurance company, or
4. Certificate of Deposit, or
5. Substitute Security agreed to by AHCCCS

**Cash Deposit**

I. Deposit of Funds

A. Any funds to be deposited with the State Treasurer shall be sent to the AHCCCS Division of Health Care Management (DHCM) in the form of a check. Along with the check should be a letter describing:

1. The application of funds (Acute, ALTCS or any combination of both)
2. A primary contact and phone number, for any issues concerning the deposit
3. Instructions for the interest from the deposit: interest to be disbursed must also include directions of where the interest is to be sent.

B. After the funds have been deposited, AHCCCS DHCM will send a copy of the "State Treasurer's Securities Safekeeping" form that records the deposit.

C. Based on instructions with the deposit, a warrant will be issued each month for the interest on the account.

D. The State Treasurer will furnish statements of the account only upon written request. This request may be made at any time.

II. Withdrawal of Funds

A. To withdraw principal funds, send a letter to AHCCCS DHCM requesting the withdrawal. The letter must include:

1. The amount of the withdrawal
2. The program that the funds are being withdrawn from (Acute or ALTCS)
3. The date that the funds should be withdrawn, (allow a minimum of ten working days)
4. The manner the warrant from the State Treasurer's office is to be handled,
    a. Mailed by the US Postal Service
    b. Courier pick-up (please include a phone number of the primary contact so prompt notice can be given
    c. Wiring instructions

B. AHCCCS DHCM will forward the warrant in the manner requested in the withdrawal letter.

**Letter of Credit**

I. Establishment of Bond

A. Before a Letter of Credit can be accepted as a PB it must be approved by AHCCCSA for form and amount. Requirements include:

1. Be of standard commercial scope and issued by a bank, credit union or savings and loans doing business in the State of Arizona and insured by the appropriate Federal Institution.
2. For an amount that meets or exceeds the PB dollar requirement.
3. For a time period that meets or exceeds the AHCCCS contract term plus three months.
4. AHCCCS DHCM must receive a signed extension 30 days prior to the expiration date.
5. A statement that the PB cannot be changed in the amount, duration or scope, or discontinued without the authorization of AHCCCS DHCM.

B. Send a copy of the agreement to be executed to AHCCCS DHCM thirty working days prior to the execution date. AHCCCS will review the agreement and advise of acceptance or that changes are necessary. The AHCCCS review will only be for issues that are necessary for the AHCCCS PB, it will not include review for any other matters.

C. AHCCCS DHCM will forward the letter of credit to our outside counsel for review.

D. AHCCCS DHCM will respond in writing that the PB is acceptable or changes need to be made for acceptance.

E. E. After the agreement is executed, send a statutory notice of deposit form and the original to AHCCCS DHCM. The original will be held in safe keeping until the agreement ends or is terminated by the parties. Make copies for your file prior to sending the original to AHCCCS DHCM.

II. Return of Letter of Credit original

A. The original Letter of Credit will be returned to the makers upon:

1. Termination of the Letter of Credit, or
2. Termination of the AHCCCS contract, or
3. Satisfying the PB requirement with another acceptable form as outlined by AHCCCS.
4. Statutory Notice of Release form

**Surety Bond**

I. Establishment of Bond

A. Before a Surety Bond can be accepted as a PB it must be approved by AHCCCS administration for form and amount. Requirements include:

1. Be of standard commercial scope and issued by a bank, credit union, savings and loans, or insurance company authorized to do business in the State of Arizona and insured by the appropriate Federal Institution.
2. For an amount that meets or exceeds the PB dollar requirement.
3. For a time period that meets or exceeds the AHCCCS contract term plus three months.
4. AHCCCS Division of Health Care Management (DHCM) must receive a signed extension 30 days prior to the expiration date.
5. A statement that the PB cannot be changed in the amount, duration or scope or discontinued without the authorization of AHCCCS DHCM.

B. Send a copy of the agreement to be executed to AHCCCS DHCM thirty working days prior to the execution date. AHCCCS will review the agreement and advise of acceptance or that changes are necessary. The AHCCCS review will only be for issues necessary for the AHCCCS PB; it will not include review for any other matters.

C. AHCCCS DHCM will forward the surety bond to our outside counsel for review.

D. AHCCCS DHCM will respond in writing whether the PB is acceptable or changes need to be made for acceptance.

E. After the agreement is executed, send a Statutory Notice of Deposit form and the original to AHCCCS DHCM. The original will be held in safe keeping until the agreement ends or is terminated by the parities. Make copies for your file prior to sending the original to AHCCCS DHCM.

III. Return of Surety Bond original

A. The original Surety Bond will be returned to the makers upon:

1. Termination of the Surety bond, or
2. Termination of the AHCCCS contract, or
3. Satisfying the PB requirement with another acceptable form as outlined by AHCCCS
4. Statutory Notice of Release

## IV. Certificate of Deposits

I. Types of Certificate of Deposits

Only Certificates of Deposit from banks, savings and loans, or credit unions and insured by the appropriate Federal institution, are applicable for the Performance Bond.

II. Assignment to Arizona State Treasurer

All Certificate of Deposit must be assigned to the Arizona State Treasurer in compliance with Arizona Revised Statute Section 35-155. This can be accomplished with the "Assignment to Arizona State Treasurer" form.

II. Deposit of the Certificate of Deposit

A. Send or deliver the original Certificate of Deposit (or receipt for the Certificate of Deposit if a certificate is not issued) and the Assignment form to AHCCCS DHCM. A letter should accompany the Certificate of Deposit describing the form of PB the Certificate of Deposit is satisfying (Acute or ALTCS) and a contact person. Also, a Statutory Notice of Deposit form should accompany the Certificate of Deposit.

B. After the Certificate of Deposit has been sent to the State Treasurer, AHCCCS DHCM will send copy of the State Treasurer's "Securities Safekeeping" form to record the deposit of the Certificate of Deposit.

C. After the Certificate of Deposit has been deposited with the State Treasurer it is the Health Plan's responsibility to monitor the maturity date. No notification should be expected from the State Treasurer's office or AHCCCS DHCM. Evidence of the renewal of each CD must be sent to AHCCCS DHCM within 5 days of the renewal date.

IV. Withdrawal of a Certificate

A. Send a letter to AHCCCS DHCM requesting the release of a specific Certificate of Deposit giving:

1. The institution of the Certificate of Deposit,
2. The certificate number,
3. The amount of the Certificate of Deposit,
4. The program the Certificate of Deposit is being withdrawn from,
5. The manner the Certificate of Deposit is to be returned to the Plan,
6. A contact person, and
7. Statutory Notice of Release form

**Securities**

I. Acceptable Securities

The following list is an outline of the acceptable and unacceptable securities that may be posted as a PB. The listing is not comprehensive but it includes the most common securities.

Acceptable:

A. United States Treasury Bills
B. United States Treasury Notes
C. United States Treasury Bonds
D. Federal Farm Credit Banks Funding Corporation Bonds
E. Federal Home Loan Bank Bonds
F. Federal National Mortgage Association (Fannie Mae) Coupon Interest Bonds

Unacceptable:

A. Federal Home Loan Mortgage Corporation
B. Government National Mortgage Association
C. Municipal Bonds
D. Corporate Bonds
E. Commercial Paper
F. Stocks
G. Letter of Credit from other than a bank, savings and loan or credit union
H. Bankers Acceptance
I. Mutual Funds

II. Deposit of Security as PB

A. Execute a "Statutory Deposit Custody Agreement" with the State Treasurer's appointed custodian.

B. The face amount of the security or principal amount of the purchase price, whichever is lower, must be equal to or greater than the PB requirement. On an ongoing basis, the lower of cost or market must be equal to or greater than the PB requirement.

C. After deciding on one of the securities to be used as a PB, fill out a "Notice of Statutory Deposit Delivery" form and submit the form and security if not in Book Entry form, to AHCCCS DHCM. Include a letter that details the reason for the deposit of the security and a contact person.

D. AHCCCS DHCM will forward the Notice of Statutory Deposit Delivery form (and security if applicable) to the State Treasurer's appointed custodian who will then,

1. Effect the transfer from the purchasing agent, or
2. Make the purchase as directed

E. The security will remain in the safekeeping of the State Treasurer's appointed custodian. Any interest distributions will be accomplished through instructions to the appointed custodian and require no intervention by AHCCCS DHCM. (Only interest on Coupon Interest Bonds is available for distribution, interest on Discount Interest Bonds must remain in the account to satisfy the maturity amount).

F. Confirmation statement to be received by DHCM from State Treasurer's appointed custodian acknowledging transaction completed.

III. Release of Security as a Performance Bond

A. Fill out a "Notice of Statutory Deposit Release" form and send it along with a letter of explanation to AHCCCS DHCM.

B. AHCCCS DHCM will forward the Notice of Statutory Deposit Release form to the State Treasurer's appointed custodian. The custodian will then release the security in the manner instructed in the Notice of Statutory Deposit Release form.

## IV. References

RFP Section D, *Performance Bond or Bond Substitute and Amount of Performance Bond*

## CHAPTER 400 – OPERATIONS PAGE

# 401 - CHANGE OF PLAN: ACUTE CARE CONTRACTORS (HEALTH PLANS)

Effective Date: 08/01/94
Revision Date: 02/01/03

Staff responsible for policy: DHCM Operations

## I. Purpose

This policy applies to Acute Care Contractors (hereafter referred to as Contractors). This policy establishes guidelines, criteria and timeframes for how, when and by whom change requests will be processed for Title XIX and Title XXI members. This policy delineates the rights, obligations and responsibilities of:

- The member
- The member's current Contractor
- The requested Contractor, and
- The AHCCCSA,

in facilitating continuity of care, quality of care and efficient and effective program operations and in responding to administrative issues regarding member notification and errors in assignment.

## II. Definitions

**Day:** A calendar day, unless otherwise specified

## III. Policy

### A. Criteria For Change Of Plan Approval

Plan change requests will be granted for members if certain conditions are met. These conditions are:

**1. Administrative Actions Resulting in a Request for a Health Plan Change**

a. A member was entitled to freedom of choice, but was not given a pre-enrollment notice or sent an auto-assignment/freedom of choice notice. Title XXI members must choose a health plan prior to eligibility being effective. If a Title XXI member is transferred from Title XIX to Title XXI, and the Title XXI member has not made a health plan choice, the Title XXI member will continue to be enrolled in the health plan they were enrolled in at the time of transfer. They will then be sent and enrollment choice notice giving them all Title XXI enrollment choices and an opportunity to select a health plan.

b. A member was entitled to participate in an Annual Enrollment Choice but:
   1) was not sent an Annual Enrollment Choice or
   2) was sent and Annual Enrollment Choice notice but was unable to participate in the Annual Enrollment Choice due to circumstances beyond the member's control.

c. Family members were inadvertently enrolled in different health plans (this paragraph does not apply to Title XXI members). A member who is enrolled in a health plan through the auto-assignment process may inadvertently be enrolled in a different health plan than other family members. In this case, the member who was inadvertently enrolled will be disenrolled from the health plan of assignment and enrolled in the health plan where the other family members are enrolled when AHCCCS is notified of the problem. Other family members will not be permitted to change to the health plan to which the new member was auto-assigned. However, the condition set forth in the paragraph shall not apply if a member was afforded an enrollment choice during their Annual Enrollment Choice period.

d. A member of a special group is not enrolled in the same health plan as the group, in accordance with the AHCCCSA's list of special group agreements (this paragraph does not apply to Title XXI members). If a member who is part of such a special group is inadvertently enrolled in the wrong health plan, AHCCCS, upon notification, will disenroll the member from the health plan and enroll the member in the special group health plan.

e. A member who was enrolled in a health plan, lost eligibility and was disenrolled, then was subsequently redetermined eligible and reenrolled in a different health plan within 90 days from the date of disenrollment. In this case the member should be reenrolled in the health plan that the member was enrolled in the prior to the loss of eligibility. If this does not occur, AHCCCS, upon notification, will enroll the member in the correct health plan. Title XXI members who loose eligibility and subsequently re-apply must choose a health plan prior to being made eligible regardless of the length of time between eligibility periods.

f. A Title XIX applicant who made a pre-enrollment choice and was denied Title XIX, but determined Title XXI eligible will be granted their Title XIX pre-enrollment choice. The person will be advised of their approval for Title XXI. The member will have 16 days to make a Title XXI choice. If the member does not change their choice within this timeframe the member will remain with their Title XIX choice. If the Title XIX applicant did not pre-enroll and was subsequently approved for Title XXI, the member will be contacted to obtain a Title XXI choice.

g. Newborns will automatically be assigned to the mother's health plan. If the mother is Title XIX or Title XXI eligible she will be given 16 days from notification to select another health plan for the newborn. Newborns of Federal Emergency Services (FES) mothers will be auto assigned and the mother will be given 16 days from notification to select another health plan.

h. Adoption subsidy children will be auto-assigned and the guardian will be given 16 days from notification to select another health plan.

i. A Title XIX eligible member who is entitled to freedom of choice but becomes eligible and is auto-assigned prior to having the full choice period of 16 days. The member will be given an opportunity to request a plan change following auto-assignment, however, the member must request a plan change within 16 days from the interview date (application record receipt date) or receipt of the choice letter. A member who does not make a selection within 16 days will remain with the auto-assigned health plan.

j. A member whose eligibility category changed from SOBRA to the SOBRA Family Planning Extension Program may change their health plan if their current PCP will not be providing Family Planning Extension Program services.

**2. Medical Continuity Of Prenatal Care**

a. A pregnant member who is enrolled in a health plan through auto-assignment or freedom of choice, but who is receiving or has received prenatal care from a provider who is affiliated with another health plan, may be granted a medical continuity plan change if the medical directors of both health plans concur.

b. If there are other individuals in the pregnant member's family who are also AHCCCS eligible and enrolled, they have the option to remain with the current plan or go to the new plan if the medical continuity plan change is granted. The member may not return to the original health plan or change to another health plan after the medical continuity plan change has been granted except during the annual enrollment choice period.

c. The member must be transitioned within the requirements and protocols in the AHCCCS Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy and in the AHCCCS Medical Policy Manual, Chapter 500.

**3. Medical Continuity Of Care**

a. AHCCCS has standards for network composition that result in uniform availability and accessibility of services from all health plans serving a specific geographic area. It is impossible for the standards to cover and respond to the array of circumstances that may occur in actual delivery of, medical/health care services. In unique situations, special plan changes may be approved on a case-by-case basis if necessary to ensure the member access to medical /health care.

b. A plan change for medical continuity is not an automatic process. The member's PCP, or other medical provider, must provide documentation to both health plans that supports the need for a health plan change. The health plan(s) must be reasonable in the request for documentation. However, the burden of proof that a plan change is necessary rests with the member's medical provider. The Plan change must be approved by both health plan Medical Directors.

c. When the Medical Directors of both the receiving and relinquishing health plans have discussed the request and have not been able to come to an agreement, the relinquishing health plan shall submit the request to the AHCCCS Chief Medical Officer (CMO) or designee. The AHCCCS Acute Care Change of Plan Form (ATTACHMENT A) and the supporting documentation must be sent to the AHCCCS DHCM/CQM Manager within 14 business days from the date of the original request.

   The results of the review will be shared with both Medical Directors. The relinquishing health plan will be responsible for issuing a final decision to the member. If the member request is denied, the relinquishing health plan will send the member a notice of action.

d. The member must be transitioned within the requirements and protocols in the AHCCCS Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy and in the AHCCCS Medical Policy Manual, Chapter 500.

## B. Responsibility For Processing, Evaluation And Approval

### 1. Current Health Plan Responsibilities When A Plan Change Is Not Warranted

a. The current health plan has the responsibility to promptly address the member's concerns regarding availability and accessibility of service and quality of medical care delivery issues that may have caused a plan change request These issues include, but are not limited to:

1) Quality of medical care delivery

2) Transportation convenience

3) Transportation service availability

4) Physician or provider preference

5) Physician or provider recommendation

6) Physician or provider office hours

7) Timing of appointments and services

8) Office waiting time

b. Additionally, the health plan must explore all options available to the member, such as resolving transportation problems, provider availability issues, allowing the member to choose another PCP, or to see another medical provider, if appropriate.

c. Quality of care and delivery of medical services issues raised by the member must be referred to the current health plan's quality management staff and/or the health plan's Medical Director for review within one day of the health plan's receipt/notification of the problem.

d. The delivery of covered services remains the responsibility of the current health plan if a plan change for medical continuity of prenatal or other medical care is not approved.

e. The current health plan must notify the member, in writing, that a plan change is not warranted. If the plan change request was the result of a member concern, as defined in section B(1)(a) of this policy, the notice must include the health plan's resolution of this concern. The notice must also advise the member of the AHCCCS and health plan grievance policy and include timeframes for filing a grievance.

f. Health plans may reach an agreement with an out-of-network provider, to care for the member on a temporary basis, for the members' period of illness and/or pregnancy in order to provide continuity of care.

**2. Current (Sending) Health Plan Responsibilities When A Plan Change Is Warranted**

a. If a member contacts the current health plan, verbally or in writing, and states that the reason for the plan change request is due to situations defined in Section A(1) of this policy, the sending/current health plan shall advise the member to telephone the AHCCCS Verification Unit at 417-7000 or 1-800-962-6690 in order for AHCCCS to process the change.

b. If the member contacts the sending/current health plan, verbally or in writing, to request a plan change for medical continuity of care as defined in A(2) or A(3) of this policy, the following steps must be taken:

1) The sending/current health plan will contact the receiving health plan to discuss the request. If a plan change is indicated for medical continuity of care, the AHCCCS Plan Change Request form (Attachment A) must be completed. All the members to be affected are added to the form and the form signed by the medical directors or physician designees of both health plans. When the AHCCCS Plan Change Request form is signed it is to be submitted to the AHCCCS Division of Member Services (DMS) Enrollment Unit.

2) To facilitate continuity of prenatal care for the member, health plans shall sign off and forward the AHCCCS Plan Change Request form to the AHCCCS DMS Enrollment Unit Manager within 2 working days of the member's plan change request. The timeframe for other continuity of care issues is 10 business days.

3) The Enrollment Unit Manager will review the plan change documentation and forward to the Enrollment Unit for processing.

4) The enrollment Unit will consider these plan changes as an administrative plan change.

c. The member must be transitioned within the requirements and protocols in the AHCCCS Member Transition for Annual enrollment Choice, Open Enrollment and Other Plan Changes Policy and in the AHCCCS Medical Policy Manual, Chapter 500.

**3. Notification Requirements**

The health plan will provide notification to its physicians and members of this policy. Information regarding this policy must be included in the provider manual and in the member handbook.

**4. Receiving Health Plan Responsibilities**

The member must be transitioned within the requirements and protocols in the AHCCCS Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy and in the AHCCCS Medical Policy Manual, Chapter 500.

**5. Member responsibilities**

a. The member shall request a change of plan directly from AHCCCS only for situations defined in Section A(1) of this policy. The member shall direct all other plan change requests to the member's current health plan.

b. A member who has questions or concerns about the Plan Change Policy should be first advised about the options available to the member and the steps the health plan is required to take to accommodate medically necessary services. If the member continues to present questions or concerns, the member should be advised of the AHCCCS/Health Plan Grievance Policy, including timeframes for filing a grievance.

**C. AHCCCS Administration Responsibilities**

1. The AHCCCSA shall process change of plan requests that are listed in Section A(1) and shall send notification of the change via the daily recipient roster to the sending and receiving health plans. It is the health plan's responsibility to identify members from the daily recipient roster who are leaving the health plan.

   Additionally, AHCCCSA will send the relinquishing health plan's transition coordinator a Prior Plan letter. The Prior Plan letter is system generated and mailed on a daily basis. The letter includes the transitioning member's name, AHCCCS ID, date of birth, and the name of the receiving health plan.

   If the AHCCCSA denies a Section A(1) change of plan request, AHCCCSA will send the member a denial letter. The member will be given 60 days to file a grievance.

2. If AHCCCSA receives a letter or verbal request from a member wanting a plan change, for reasons defined in Section A(1) of this policy, that also references other problems (i.e., transportation, accessibility or availability of services), that information will be sent to the current health plan.

3. If AHCCCSA receives a letter or verbal request from a member wanting a plan change for reasons listed in Section A(2) or A(3) the information will be forwarded to the current health plan.

## IV. References

- 9 A.A.C. 22, Article 5 and 9 A.A.C. 31, Articles 3 and 5
- Acute Care Contract, Section D
- ALTCS Contract, Section D
- AHCCCS Medical Policy Manual, Chapter 500
- Attachment A

**Attachment A**

# MEMBER REQUEST FOR PLAN CHANGE

**CHANGE REASON:** ☐**Medical Continuity of Prenatal Care** ☐**Medical Continuity of Care**

## MEMBER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Member Name: | | Member ID: | | Phone#: | - - |
| Address: | | Apt/Space#: | | DOB: | - - Sex: |
| City: | | State: | | ZIP: | |
| Member's PCP: | | AHCCCS ID#: | | Phone#: | - - |

| **CURRENT (Sending) Health Plan:** | | **Receiving Health Plan**: | |
|---|---|---|---|
| Health Plan Name: | | Health Plan Name: | |
| Health Plan ID#: | | Health Plan ID#: | |
| Contact Name: | | Contact Name: | |
| Contact Phone: | | Contact Phone: | |
| Contact Fax: | | Contact Fax: | |

## PROVIDER REQUESTED FOR CONTINUITY

| | | | | | |
|---|---|---|---|---|---|
| Provider Name: | | AHCCCS ID#: | | Phone# | - - |

## DOCUMENTATION OF MEDICAL CONTINUITY

(include all information supporting the need for the change)

Member requests change of plan to:

Member's effective date is: - -  Rate Codes:

☐ Approved ☐ Denied ☐ Approved ☐ Denied

Medical Directo5r's Signature/Sending Plan

Medical Director's Signature/Receiving Plan

Reason stated for denial by Receiving Plan:

**PLEASE ATTACH ANY RELEVANT DOCUMENTATION**

☐ Documentation Attached ☐ Additional family members listed on attached page

After review by AHCCCSA this plan change has been: ☐ Approved ☐ Denied

AHCCCS Medical Director (for Designee)

Date

Any plan change request processed by the health plans must involve continuity of care issues. If a plan change is requested for any other reason, the request should be managed according to the AHCCCS Change of Plan Policy.

# 402 - MEMBER TRANSITION FOR ANNUAL ENROLLMENT CHOICE, OPEN ENROLLMENT AND OTHER PLAN CHANGES: ACUTE CARE AND ARIZONA LONG TERM CARE SYSTEM (ALTCS) CONTRACTORS

Effective Date: 08/01/95
Revision Date: 02/01/03

Staff responsible for policy: DHCM Operations

## I. Purpose

This policy applies to all Acute Care and Arizona Long Term Care System (ALTCS) Contractors (hereafter referred to as Contractors). This policy establishes guidelines, criteria and timeframes for how members are to be transitioned between AHCCCS Contractors. This policy delineates the rights, obligations and responsibilities of, the member's current Contractor and the requested (receiving) Contractor.

The Contractors and AHCCCS work together to ensure the smooth transition of members as they change from one Contractor to another. While administrative and financial considerations are involved, the overriding consideration should be a smooth transition for all members and ensuring that continuity and quality of care are maintained.

This policy applies to members transitioning in the following circumstances.

### A. Annual Enrollment Choice

Annual enrollment choice provides AHCCCS members with the opportunity to change Acute Care Contractors once per year, subject to the availability of other contracted Acute Care Contractors in their area.

Members must notify AHCCCS of their wish to change Acute Care Contractors during the annual enrollment choice period. If the member does not participate in annual enrollment choice, and their eligibility is maintained, he/she will remain with their current Acute Care Contractor.

### B. Open Enrollment

AHCCCS may also conduct an open enrollment on a limited basis as deemed necessary by the AHCCCS Administration. Members must notify AHCCCS of their wish to change Acute Care Contractors during open enrollment.

If the member does not participate in open enrollment and their eligibility is maintained, he/she will remain with their current Acute Care Contractor unless the Acute Care Contractor is no longer available in that Geographic Service Area (GSA).

### C. Contractor Changes Permitted by Policy

Members who have been granted a plan change pursuant to the AHCCCS Change of Plan Policy.

### D. Eligibility Changes

Members who have changed eligibility from Acute to the ALTCS or from ALTCS to Acute.

Members who have become eligible and have enrolled into the Children's Rehabilitative Services (CRS) program while maintaining enrollment with an Acute or ALTCS Contractor, or members who have lost eligibility for CRS, but remained eligible for either the Acute or ALTCS program.

Each AHCCCS Contractor will participate in the transition of members. Contractors must have in place the necessary policies and procedures for the acceptance and transfer of members.

Transition coordination activities must include, but are not limited to, compliance with AHCCCS standards and policies found in the AHCCCS Medical Policy Manual, Chapter 500. The cost of reproducing and forwarding member records will be the responsibility of the relinquishing Acute Care Contractor and its providers.

This policy does not apply to members transitioning between Indian Health Service (IHS) and a Contractor.

## II. Definitions

**Annual enrollment choice:** The annual opportunity for a member to change his/her Acute Care Contractor. The member is given their annual enrollment choice in the 10$^{th}$ month following their anniversary date. If an individual member makes a timely (within the period stated on the annual choice letter) annual enrollment choice, the change in Acute Care Contractors will occur on the first of the month in which their anniversary date occurs.

**Anniversary date:** The first day of the month in which a case (Members who share the same household identification number or a single person household) has Acute eligibility updated. Those Title XIX members within the case who had a break in eligibility and were reenrolled within 90 days will cause the entire case to have the break in eligibility ignored when calculating the anniversary month.

**Case:** Members who share the same household identification number.

**Children's Rehabilitative Service (CRS):** serves individuals under 21 years of age who meet the criteria established by Arizona Department of Health Services. CRS has a contract with AHCCCS for the provision of care for specific conditions. Members may be concurrently enrolled with CRS and with a Contractor.

**Enrollment Transition Information Form (ETI):** The form the Relinquishing Contractor must complete and transmit to the Receiving Contractor for those members requiring coordination of services as a result of transitioning to another Contractor. (See AHCCCS Medical Policy Manual, Chapter 500).

**Indian Health Service (IHS):** Indian Health Service is a division of the U. S. Public Health Service. It administers a system of hospitals and health care centers providing health services to Native Americans and Native Alaskans.

**Member Transition:** The process during which members change from one Acute Care Contractor to another, change from the Acute to the ALTCS program, change from ALTCS to the Acute program, change from one ALTCS Contractor to another, or enroll or disenroll from CRS.

**Open enrollment:** The period of time when selected enrolled members in an affected GSA or Acute Care Contractor may select membership with another AHCCCS Acute Care Contractor if one is available in their service area.

**Plan change:** The process where a member changes Acute Care Contractors whether during Annual Enrollment Choice, Open Enrollment or Pursuant to the AHCCCS "Change of Plan Policy".

**Receiving Contractor:** The Contractor with which the member will become enrolled as a result of annual enrollment choice, open enrollment, a plan change or a change in eligibility.

**Regional Behavioral Health Authority (RBHA):** The Regional Behavioral Health Authority is an organization under contract with the Arizona Department of Health Services to coordinate the delivery of behavioral health services in a geographically specific service area of the state.

**Relinquishing Contractor:** The Contractor in which the member is currently enrolled. This is the Contractor that the member will be leaving as a result of annual enrollment choice, open enrollment, a plan change or a change in eligibility.

**Transition coordinator:** A designated Contractor health care professional who is responsible for the oversight of transition activities.

**Transition plan:** A documented plan (policy) which details the Contractor's protocols, standards and procedures for performing transition activities for members joining and leaving the Contractor. The Contractor's transition plan must be approved in writing by AHCCCSA prior to implementation.

## III. Policy

### A. Contractor Responsibilities During Annual Enrollment Choice, Open Enrollment And Other Contractor Changes

1. Relinquishing and receiving Contractors must comply with all transition policies specified in the AHCCCS Medical Policy Manual Chapter 500.

2. Relinquishing Contractors who fail to notify receiving Contractors about members that meet the AHCCCS transition notification requirements, as indicated in the AHCCCS Medical Policy Manual Chapter 500, may be responsible for the cost of the member's care for medically necessary services for up to 30 days after the transition. The scope and responsibility for such cases will be reviewed and determined by the AHCCCS Administration. In cases where AHCCCS determines that the relinquishing Contractor has a period of responsibility following the transition date, AHCCCS will require the receiving Contractor to provide AHCCCS with information about all cost incurred by the member during the period determined by AHCCCS. Failure to provide the information to AHCCCS as specified by AHCCCS and by the date specified by AHCCCS will negate the receiving Contractor's claim to reimbursement in that case.

3. Each Contractor must develop and submit a transition plan and designate a transition coordinator who meets the requirements addressed in this policy. Contractors are also encouraged to designate an information system staff member or representative to work with transition coordinators to assist with the technical requirements necessary for member transition.

4. Contractor representatives must be accessible for members participating in annual enrollment choice or open enrollment. These representatives must have the authority to respond to member and provider concerns and facilitate problem resolution.

### B. Relinquishing Contractor Responsibilities

1. Relinquishing Contractors must complete and transmit an Enrollment Transition Information (ETI) form for each member with special circumstances, as described in the AHCCCS Medical Policy Manual, Chapter 500, and must comply with the notification requirements specified in this policy. If there is no pertinent information to transmit concerning a member who is transitioning, no action is required.

2. Relinquishing Contractors that fail to notify receiving Contractors of members that meet the AHCCCS transition notification requirements as indicated in the AHCCCS Medical Policy Manual, Chapter 500, may be responsible for the cost of the member's care for medically necessary services for up to 30 days after the transition. The scope and responsibility for such cases will be reviewed and determined by AHCCCS Administration.

3. Relinquishing Contractors with transitioning members who are hospitalized at the time of transition must notify the hospital prior to transitioning the member and must comply with the requirements of the AHCCCS Medical Policy Manual, Chapter 500. For those hospitalized transitioning members in intensive care units, critical care units, and neonatal intensive care units, close consultation between attending physicians, current primary care provider (PCP) and the member's receiving Contractor and PCP is required.

4. The Relinquishing Contractor is responsible for ensuring that a transitioning member's medical records are copied and mailed when requested by the receiving Contractor's transition coordinator, the member's new PCP, or his/her designated office staff. In cases where additional information is medically necessary but is exceptionally lengthy, the relinquishing Contractor is responsible for the cost of copying and postage. Under no circumstances is the member required to pay fees or costs associated with the copying and/or transfer of medical records to the receiving Contractor.

5. For members changing Contractors or changing to or from ALTCS, all AHCCCS Contractors must cover and deliver medically necessary services to their assigned members through the date of transition. Under no circumstances may a Contractor cancel, postpone, or deny a service based on the fact that a member will be transitioning to another Contractor except as discussed in AMPM, Chapter 500.

   Additionally, Contractors are responsible for ensuring that all staff involved with the coordination and/or authorization of services between members and providers are aware of the Acute Care Contractor's duties and obligations to deliver medically necessary services to transitioning members through the date of transition.

6. The relinquishing Contractor will remain responsible for adjudicating any pending member grievances that are filed prior to the member's transition.

7. If an ALTCS member is no longer ALTCS eligible but is eligible for acute care the relinquishing Contractor is responsible for obtaining the member's choice of acute care Acute Care Contractor and notifying AHCCCS, as a part of the ALTCS disenrollment process, when the member is transitioning from ALTCS to Acute.

8. If a member enrolled in a Contractor becomes eligible and enrolls in CRS, the member's Contractor and CRSA, or its subcontractor, must cooperate in the coordination of care for the member.

9. If a member enrolled in CRS is no longer eligible for CRS, but remains eligible for the Acute or ALTCS programs, CRSA, or its subcontractor, is responsible for contacting the member's Contractor to coordinate care for the transitioning member's CRS condition.

## C. Receiving Contractor Responsibilities

Receiving Contractors that fail to act upon enrollment transition information communicated by the relinquishing Contractor for members that meet the AHCCCS notification requirements, or fail to coordinate or provide the necessary covered services to transitioning members after being properly notified in a timely manner, will be subject to possible sanctions.

1. Within 10 business days for Acute Care members and 12 days for ALTCS members (allows for case management on-site visit) of the effective date of transition, the receiving Contractor must provide new members with member information as specified in the AHCCCS Member Information Policy.

2. Receiving Contractors are responsible for ensuring that:

   a) Transitioning members are assigned to a PCP in accordance with AHCCCS requirements.

   b) Transitioning members can obtain routine, urgent, and emergent medical care in accordance with AHCCCS standards.

3. When a pregnant woman who is considered high-risk and is in her third trimester or a member who is anticipated to deliver within 30 days of transition, elects to remain with her current physician through delivery, the receiving Contractor is responsible for the payment of obstetrical and delivery services. If the member's current physician and/or facility selected as her delivery site are not within the receiving Contractor's provider network, the receiving Contractor must negotiate for continued care with the member's provider of choice for payment of obstetrical services even if delivery is scheduled to occur outside of the receiving Contractor's contracted network.

4. For members receiving behavioral health services through an ADHS Contractor, the receiving Contractor is responsible for notification about the enrollment changes (if known), coordination of behavioral health services, and case management with the member's assigned Regional Behavioral Health Authority.

5. The receiving Contractor is responsible for maintaining ongoing communication with the transition coordinator of the relinquishing Contractor and ensuring all appropriate documents (i.e., medical records if requested, treatment plans, etc.) are received in a timely manner or as specified by both Contractors.

## D. Member Responsibilities During Annual Enrollment Choice

1. Members are encouraged to thoroughly review all AHCCCS and Acute Care Contractor annual enrollment choice material, call the prospective Acute Care Contractors, and ask questions prior to making a decision.

   Members must maintain eligibility to stay enrolled with AHCCCS. If a Title XIX member loses eligibility after making an annual enrollment choice and regains eligibility prior to the 90-day reenrollment period, the member's annual enrollment choice will be honored. If the member regains eligibility after the 90-day re-enrollment period, he/she will lose their annual enrollment choice. If a Title XIX member regains eligibility after the 90-day period and did not make a pre-enrollment choice, he/she will be auto-assigned to an available Acute Care Contractor. If a Title XXI member loses eligibility after making an annual enrollment choice and regains eligibility within the 90-day period the annual enrollment choice will not be honored. The member must make another enrollment choice.

2. Members who change Acute Care Contractors during their annual enrollment choice will not receive services from their new Acute Care Contractor (receiving Acute Care Contractor) until the first day of the month in which their anniversary date occurs. Members will continue to receive their medical care from their current AHCCCS Acute Care Contractor (relinquishing Acute Care Contractor) through the end of the month previous to the anniversary date. If the member does not make a choice before the last day of the month the member will not receive services from their new Acute Care Contractor (receiving Acute Care Contractor) until the first day of the month following their anniversary month. Members will continue to receive their medical care from their current AHCCCS Acute Care Contractor (relinquishing Acute Care Contractor) through the end of the month of the anniversary date.

3. Members who elect to change their Acute Care Contractor during their annual enrollment choice must notify AHCCCS of their choice. If members are satisfied with their current Acute Care Contractor and do not wish to change, no action on the part of the member is required unless their Acute Care Contractor is no longer available in the member's GSA. Members will receive instruction on how to change Acute Care Contractors or remain with their current Acute Care Contractor in the annual enrollment choice packet.

## E. Transition Plan

1. Contractors must submit a transition plan to AHCCCS within the time lines set by AHCCCS. The transition coordinators will be notified, in writing, of the date the transition plan is due to AHCCCS. The transition plan must be approved by AHCCCS prior to implementation. The scope of the transition plan must address the transition of new and existing members. Contractors should refer to the authority references listed on page 10 of this policy when developing their transition plans.

2. At a minimum, transition plans must address the following areas:

    a) Transition notification requirements as indicated in the AHCCCS Medical Policy Manual

    b) Timely notification to receiving Contractors of transitioning members no later that 10 business days from the date of the potential transition listing (for annual enrollment choice and open enrollment) or the daily roster (for all other Contractor changes)

    c) PCP assignment procedures

    d) Case management assignment for Contractors

    e) General communication and coordination of member transition activities

    f) Procedures for transfer of medical records and coordination of services between PCPs

    g) Procedures for recording the number of behavioral health and nursing facility services for transitioning members

## F. Transition Coordinator

Contractors must identify a representative to serve as transition coordinator. The individual appointed to this position must be a health care professional who possesses the appropriate education and experience to effectively coordinate and oversee all transition issues, responsibilities, and activities. The role of the transition coordinator includes:

1. Coordinating plan change transition activities

2. Ensuring that transition activities are accomplished in accordance with AHCCCS and Contractor policies and procedures

3. Acting as an advocate for members leaving and joining the Contractor

4. Facilitating communication between Contractors and AHCCCS

5. Assisting PCPs, internal Contractor departments, and other contracted providers with the coordination of care for transitioning members

6. Ensuring that continuity and quality of care of transitioning members is maintained during Contractor transitions

7. Participating in AHCCCS Acute Care Contractor transition coordinator's planning meetings

8. Assisting AHCCCS Administration with developing transition policy, procedures, and standards

## G. Potential Transition Listing

To assist with the identification of members who have made an annual enrollment choice and will be transitioning between Acute Care Contractors as a result of the annual enrollment choice, AHCCCS will provide Acute Care Contractors with a Potential Transition Listing. This listing will be transmitted to the Acute Care Contractor via the File Transfer Protocol (FTP) server approximately two weeks before the member's enrollment effective date.

The Potential Transition Listing will include the following member information:

1. AHCCCS ID Number

2. Name and address

3. Date of birth

4. Rate code

5. Relinquishing Acute Care Contractor

6. Receiving Acute Care Contractor

7. New PCP choice by name (if identified by the member at the time of annual enrollment choice)

## IV. References

- Arizona Administrative Code R9-22, Articles 5 and 7
- Acute Care Contract, Section D
- ALTCS Contract, Section D
- AHCCCS Medical Policy Manual, Chapter 500

# 403 - ENROLLMENT CHOICE IN A CHOICE COUNTY AND CHANGE OF CONTRACTOR POLICY: ARIZONA LONG TERM CARE SYSTEM (ALTCS), ELDERLY/ PHYSICALLY DISABLED (EPD) CONTRACTORS

Effective Date: 10/01/00
Revision Date: 08/01/01

Staff responsible for policy: DHCM Operations

## I. Purpose

This policy applies to ALTCS/EPD Contractors. This policy establishes guidelines, criteria and timeframes for how, when and by whom enrollment choice in a choice county and Contractor change requests will be processed for ALTCS members. This policy applies to Arizona Long Term Care (ALTCS) Contractors only (hereafter referred to as Contractors).

This policy delineates the rights, obligations and responsibilities of:

- The member
- The member's current Contractor
- The receiving Contractor, and
- The AHCCCS Administration,

in facilitating continuity of care, quality of care and efficient and effective program operations and in responding to administrative issues regarding member notification and errors in assignment.

## II. Definitions

**ALTCS Local Office:** The ALTCS local office currently responsible for the member's financial eligibility case record.

**Anniversary Date:** The month for which the member is entitled to make an annual enrollment choice. The anniversary date is 12 months from the date enrolled with the Contractor and annually thereafter.

**Choice County or Geographic Service Area (GSA):** A county or GSA with more than one ALTCS Contractor.

**County of Fiscal Responsibility:** The county that is financially responsible for the State's share of ALTCS funding.

**Current Contractor:** The Contractor with whom the member is enrolled at the time the change request is generated.

**Day:** Day means a calendar day unless otherwise specified.

**Receiving Contractor:** The Contractor to whom the member is being changed.

**Requested Contractor:** The Contractor to whom the member wants to change.

## III. Policy

Some, but not all, ALTCS applicants and members who reside in a choice county or who are planning to move to a choice county must be offered an opportunity to choose a Contractor.

### A. Enrollment Choice in a Choice County

#### 1. Individual Entitled to Enrollment Choice

An individual is entitled to enrollment choice when:

a. An applicant resides in a choice county and a choice county is the county of fiscal responsibility.

b. A member moves from another county to his or her own home in a choice county, unless the member's current Contractor is available in the choice county.

c. A member moves from another county to a nursing facility or alternative residential setting in a choice county and the current Contractor has chosen to negotiate an enrollment change.

d. A member is currently enrolled with a Contractor serving a choice county, but a valid condition exists (see Section B) for requesting an enrollment change to another Contractor serving a choice county.

e. A former member resides in a choice county and reestablishes eligibility that results in reenrollment more than 90 days after disenrollment.

f. A member attains the annual anniversary date.

**2. Individual Who Does Not Have Enrollment Choice**

This policy does not apply to the following individuals:

a. A member who is developmentally disabled

b. A member who is a Native American with on-reservation status

c. A choice county resident whose county of fiscal responsibility is not a choice county (unless the current Contractor chooses to negotiate a change to that choice county)

d. A member who was disenrolled from a Contractor in a choice county, but subsequently reestablishes ALTCS eligibility that results in reenrollment within 90 days from disenrollment.

e. Residents of counties other than a choice county, unless a choice county is the county of fiscal responsibility.

f. A member who moves to a choice county and his or her current Contractor is available in that choice county.

**3. Initial Enrollment Process**

The initial enrollment process is used to obtain enrollment choice from an ALTCS/EPD applicant whose county of fiscal responsibility is a choice county.

| Stage | Description |
|---|---|
| 1 | ALTCS staff provides the applicant with:<br>• An explanation of enrollment choice<br>• Marketing materials from the Contractors serving the choice county.<br>• Assistance in choosing a Contractor |
| 2 | ALTCS Staff obtains an enrollment choice before the application is approved. |
| 3 | Ongoing enrollment is prospective, effective the date the application is approved.<br>Prior period coverage is effective retroactive to the first day of the first eligible month, unless the member is being transferred from an acute Contractor to an ALTCS Contractor. |

### 4. Re-enrollment After Disenrollment

When a member, whose county of fiscal responsibility is a choice county, is disenrolled due to loss of ALTCS eligibility, but is subsequently determined eligible within 90 days from the date of disenrollment, the member will be reenrolled with the former Contractor, if that Contractor is still available. If that Contractor is not available, the member will be given the opportunity to choose a Contractor.

When reenrollment occurs more than 90 days after the disenrollment, or another valid reason for change exists, the member will be given the opportunity to choose a Contractor.

When a member is reenrolled within 90 days, the anniversary date is determined by the previous enrollment date. The member may choose to enroll with a different Contractor on his/her anniversary date, which is established by the initial enrollment with that Contractor.

### 5. Enrollment Choice Process For Fiscal County Changes

An enrollment choice must be obtained before a member's enrollment can be changed to a Contractor serving a choice county. The enrollment choice process applies to an ALTCS member who moves to a choice county to:

a. His or her own home

b. A nursing facility or alternative residential setting and the current Contractor requests an enrollment choice in order to negotiate an enrollment change with a Contractor in a choice county.

The enrollment choice process consists of the following steps:

| Step | Action |
|---|---|
| 1 | The ALTCS local office provides the member with:<br>• an explanation of enrollment choice<br>• marketing materials from each of the Contractors serving a choice county<br>The member is asked to provide a choice prior to actually moving or within 10 days of our request. |
| 2 | The ALTCS local office provides the member with assistance in making the decision throughout the process. |
| 3 | When the member does not make a choice within 10 days, the ALTCS local office sends an Enrollment Choice Reminder Notice asking the member to provide a choice within the next 10 days. |

## B. Identifying & Processing Requests for Contractor Changes Within a Choice County

Generally, once enrollment occurs a member cannot change enrollment until their anniversary date. This is called Annual Enrollment. However, an enrollment change from one choice county Contractor to another choice county Contractor can be made for certain reasons.

### 1. Medical Continuity of Care Requests

In unusual situations, special Contractor changes may be approved on a case-by-case basis to ensure the member's access to care. These situations generally involve existing conditions at the time of enrollment as opposed to new conditions that develop after enrollment.

The following special process is required:

| Step | Action |
|---|---|
| 1 | The member's PCP must provide documentation to the Medical Directors of both Contractors that support the need for a Contractor change. Both Contractors must be reasonable in the request for documentation. |
| 2 | The Medical Directors of both Contractors must approve the change.<br>• In order to provide continuity of care on a temporary basis for the member's period of illness, the current Contractor may agree to reimburse the member's provider for service rather than approve a Contractor change.<br>• If one of the Contractors denies the request, the change request is forwarded to the AHCCCS Medical Director for a final decision. |
| 3 | When both Contractors approve the change the receiving Contractor sends the completed Program Contractor Change Request Form (DE-621) to the Program Contractor Change Request Coordinator at AHCCCS Central Office Field Operations.<br><br>When the requested Contractor denies the request, the DE-621 is returned to the current Contractor who may forward the DE-621 to the AHCCCS Medical Director. |

| Step | Action |
|---|---|
| 4 | If the AHCCCS Medical Director approves the change, the DE-621 is returned to the current Contractor to negotiate the effective date of the change. The current Contractor sends the DE-621 to the Program Contractor Change Request Coordinator at AHCCCS Central Office Field Operations. |
| 5 | The Program Contractor Change Request Coordinator processes the change. |
| 6 | If the change request is denied by the AHCCCS Medical Director, the Division of Health Care Management/ALTCS Unit will provide written notice of the denial including notice of appeal rights to the member and to both the current and receiving/requested Contractors. |

**2. Valid Conditions (Excluding Medical Continuity of Care)**

When any of the following conditions exist, an ALTCS local office may authorize a change of Contractors within a choice county.

a. Erroneous network information or agency error: The applicant or representative made an enrollment choice based on erroneous information regarding facility, residential setting, PCP or other provider contracting with the chosen Contractor based on information supplied by the network database, marketing materials, or agency error. Erroneous information includes omissions or failure to divulge network limitations and restrictions in the Contractor's marketing material or database submissions.

b. Lack of initial enrollment choice: An ALTCS applicant residing in a choice county is, for any reason, not offered a choice of Contractors during the application process.

c. Lack of annual enrollment choice: The member was entitled to participate in an Annual Enrollment Choice but was not sent an Annual Enrollment Choice notice or the notice was not received, or was sent an Annual Enrollment Choice notice but was unable to participate in the Annual Enrollment Choice due to circumstances beyond the member's control (i.e., member or representative was hospitalized, anniversary date fell within a 90 day disenroll/reenroll period).

d. Family continuity of care: The member, either through auto-assignment or the choice process, is not enrolled with the same Contractor as the other family members. To promote continuity of care, family members, such as married couples, may choose to be enrolled with the same Contractor.

e. Continuity of institutional or residential setting: The member's Contractor terminates their contract with the institutional or residential setting in which the member resides, and the member or the member's representative requests to change to a Contractor who contracts with their institutional or residential setting. The member must be enrolled and living in the facility at the time of the contract termination.

f. If the provider (nursing facility or alternative residential setting) terminates the contract, the Local Office will request instructions from the Division of Health Care Management/ALTCS Unit before making any changes.

g. Failure to correctly apply the 90-day reenrollment policy: The member lost ALTCS eligiblity and was disenrolled, was subsequently reapproved for ALTCS within 90 days of the disenrollment date, but was enrolled with a different Contractor.

**3. Processing Enrollment Change Requests**

The following procedures apply when a member requests a change of Contractors within a choice county

| **When…** | **Then…** |
|---|---|
| The member makes the request for a change to the Contractor and claims a valid condition exists (see pages 7 and 9). | The Contractor will report the request to the Local ALTCS Office using the ALTCS Member Change Report Form (DE-701). |
| The ALTCS local office receives a change request from a Contractor or a member | The ALTCS local office will investigate the request to determine if a valid condition exists. |
| The ALTCS local office determines that a valid change condition exists | The ALTCS local office will change the member's enrollment to the Contractor the member chooses. The enrollment change is effective the day the change is processed by the ALTCS local office. |
| The ALTCS local offices determines that the nursing facility or alternative residential setting terminated the contract | The ALTCS local office will send written request to the DHCM ALTCS Unit Manager and may change the enrollment only if approved in the response. |

| When… | Then… |
|---|---|
| The ALTCS local office determines that a valid situation does not exist | The ALTCS local office will:<br>• Send the member a Denial of Program Contractor Change Request (DE-548) denying the request and giving the member the right to appeal the decision.<br>• Refer the member to his or her current Contractor for resolution of existing issues. |

## C. Fiscal County and Enrollment Change Policies

### 1. Placements by a Contractor

When a Contractor places a member in a nursing facility or alternative residential setting in a different county (either to receive specialized treatment or because of lack of beds in the Contractor's county), the county of fiscal responsibility and enrollment do not change.

### 2. Moves initiated by the member or the member's family

When a member moves from one county to another county, the county of fiscal responsibility and enrollment are determined according to the following policies:

| If the member moves to… | Then… |
|---|---|
| His or her own home | <u>County of Fiscal Responsibility</u><br>• The county of fiscal responsibility changes to the (new county) county in which the home is located.<br><br><u>Enrollment</u><br>• Enrollment remains unchanged if the same Contractor serves both counties<br>• Enrollment changes if the member moves to a county served by a different Contractor.<br>• The Enrollment Choice process must be completed prior to enrollment and fiscal county changes if the home is located in a choice county and the current Contractor is not available in that choice county. |

| If the member moves to… | Then… |
|---|---|
| A nursing facility or an alternative residential setting | • The county of fiscal responsibility and enrollment will remain unchanged unless the current Contractor successfully negotiates a change with a Contractor serving the new county.<br>• The Enrollment Choice process must be completed prior to the negotiation process when the member moves to a choice county. |

**3. Uncoordinated Moves by the Member**

The Contractor is responsible for explaining the service limitations and exclusions to members who move out of the Contractor's service area.

The current Contractor is liable only for those services authorized by an ALTCS member's case manager.

## D. Member Moves to Own Home in Another County

When a member resides in his or her own home the following policies apply:

- The county of fiscal responsibility is the county where the member's or child's parents home is located.

- Enrollment is with a Contractor serving the geographic service area (or fiscal county) where the home is located.

- When the member moves to his or her own home in a choice county, and is not already enrolled with a Contractor serving that choice county, the member must be given an opportunity to choose a Contractor. The member will be enrolled with the Contractor selected through the enrollment choice process.

- The enrollment change and the change in county of fiscal responsibility cannot occur until the enrollment choice process is completed.

**1. Member's Responsibilities**

The member is responsible for reporting the move or anticipated move to the current Contractor and the ALTCS local office.

## 2. Contractor Responsibilities

The current Contractor is responsible for:

a. Notifying the ALTCS local office that the member moved by sending a Member Change Report (DE-701),

b. Explaining service limitations and exclusions to a member who moves out of the Contractor's service area, and

c. Transitioning the member to the new Contractor, which includes forwarding medical records and other materials to the receiving Contractor.

## 3. ALTCS Local Office Responsibilities

The ALTCS local office is responsible for:

a. Completing the enrollment choice process for members changing to a choice county,

b. Changing the member's living arrangement (if appropriate) and address when the move occurs,

c. Making necessary changes in the county of fiscal responsibility and enrollment, and

d. Making changes to eligibility and share of cost arising from the change in the member's living arrangement.

## 4. Enrollment Change Procedures

The ALTCS local office will complete the following steps:

| Step | Action |
|---|---|
| 1 | Determine if the county of fiscal responsibility and enrollment need to be changed. (The county of fiscal responsibility and enrollment may already be correct.)<br>• If a change is required, proceed to Step 2.<br>• If no change is needed, update the address and living arrangement, and share of cost, if necessary. |

| Step | Action |
|---|---|
| 2 | Complete the Enrollment Choice Process if enrollment needs to be changed to a Contractor serving a choice county. When the member is unable or unwilling to make a choice the current ALTCS local office will either select a Contractor for the member or permit auto assignment to a Contractor by PMMIS in accordance with the criteria in the Eligibility Policy Manual. |
| 3 | Process fiscal county and enrollment changes. |
| 4 | Determine if the eligibility case record should be transferred according to the criteria in Eligibility Policy Manual. |

## E. Member Moves to a Nursing Facility or Alternative Residential Setting in Another County

When the current Contractor provides services to the county where the member is moving, the enrollment and county of fiscal responsibility do not change.

When the current Contractor chooses to contract with the nursing facility or alternative residential setting, the enrollment and county of fiscal responsibility do not change.

When the current Contractor requests an enrollment change, the approval of both the current and the requested/receiving Contractor is required.

When the member moves to a choice county, the enrollment choice process must be completed before the current Contractor can initiate negotiations with a requested Contractor.

When the receiving/requested Contractor does not agree to the change, the current Contractor may request a decision from the AHCCCS Medical Director.

### 1. Member's Responsibilities

The member is responsible for reporting the move or anticipated move to the current Contractor and the ALTCS local office.

### 2. Current Contractor Responsibilities

a. When the current Contractor is notified that a member has moved to another county or plans to move to another county, and the member resides or plans to reside in a nursing facility or alternative residential setting, and the current Contractor does not serve the other county, the current Contractor has the following options:

- Retain the member and contract with an out of county provider,
- Negotiate an enrollment change, or
- Pay facility expenses for a limited number of days while plans are being made to move the member to a contracted facility. If the member refuses to move to a contracted facility, follow the non-user procedures in the AHCCCS Eligibility Policy Manual.

b. When enrollment change is the preferred option, the current Contractor is responsible for:

- Calling the ALTCS local office and requesting an enrollment choice when the move is to a choice county
- Completing a Program Contractor Change Request (DE-621) and sending it to the Contractor serving the GSA or the requested choice county Contractor, and
- Transitioning the member when a change is approved.

**3. ALTCS Local Office Responsibilities**

a. General Responsibilities

The ALTCS local office is responsible for:

- Assuring that the current Contractor is aware of the move or the member's plan to move, by contacting the current Contractor and advising the member to contact the current Contractor
- Informing the member that the current Contractor:
  - Must be involved in the placement change
  - Is only liable for services authorized by the case manager
- Changing the member's address when the move is verified, and
- Determining whether to retain or transfer the eligibility case file based on the case file transfer policy in the Eligibility Policy Manual.

b. Enrollment Choice for Transfers to a Choice County

When enrollment choice is requested by the current Contractor, the ALTCS local office is also responsible for:

- Informing the member about enrollment choice
- Providing marketing materials to the member
- Providing assistance to the member as necessary, and
- Obtaining an enrollment choice from the member and notifying the current Contractor.

**4. Requested Contractor's Responsibilities**

When a Program Contractor Change Request (DE-621) is received the requested Contractor is responsible for:

a. Approving or denying the change request by completing the DE-621, and

b. Transitioning the member when the change request is approved or the AHCCCS Medical Director directs the change.

**5. AHCCCS Medical Director's Responsibilities**

The AHCCCS Medical Director determines whether an enrollment change is appropriate when the receiving/requested Contractor denies the enrollment change and the current Contractor requests review by the AHCCCS Medical Director.

If approved, a written decision is issued to the current Contractor. If denied, a written notice of the denial including notice of appeal rights is issued to the current Contractor, the receiving/requested Contractor and the member.

**6. AHCCCS Central Office Field Operations Responsibilities**

The AHCCCS Central Office Field Operations is responsible for:

a. Processing enrollment and county of fiscal responsibility changes, and

b. Sending the ALTCS local office a copy of the DE-621.

## F. Enrollment Change Process

The following steps are involved in the enrollment change process:

| Step | Action |
|---|---|
| 1 | The member moves or indicates a desire or plan to move to a nursing facility or alternative residential setting in another county. |
| 2 | When advised of the move the ALTCS office:<br>• notifies the current Contractor,<br>• advises the member to contact the current Contractor, and<br>• warns the member about limitations on services received from out-of-network providers. |
| 3 | When the move has been verified, the ALTCS local office changes only the member's address/living arrangement, not the county of fiscal responsibility. |
| 4 | When the move is to a choice county:<br>• The current Contractor asks the ALTCS local office to complete the Enrollment Choice Process.<br>• The ALTCS local office obtains an enrollment choice and informs the current Contractor. |
| 5 | The current Contractor completes a Program Contractor Change Request (DE-621) and sends it to the Contractor serving the new county of residence. In a choice county this will be the requested Contractor.<br><br>If the Contractor serving the new county of residence denies the request, the current Contractor may forward to the AHCCCS Medical Director for a final decision. |
| 6 | When the Contractors or the AHCCCS Medical Director approves a change, the Program Contractor Change Request Coordinator at AHCCCS Central Office processes the enrollment and county of fiscal responsibility changes and notifies the ALTCS local office. The current Contractor will forward medical records and other materials to the receiving Contractor. |

| Step | Action |
|---|---|
| 7 | If the change request is denied by the AHCCCS Medical Director, the Division of Health Care Management/ALTCS Unit will provide written notice of the denial including notice of appeal rights to the member and to both the current and receiving/requested Contractors.<br><br>When the change is denied, the current Contractor continues to provide services to the member. |
| 8 | The ALTCS local office determines if the eligibility case record should be transferred according to the criteria in Eligibility Policy Manual. |

## G. The Contractor's Responsibilities

### 1. Provide Contractor change policy

Contractors are responsible for providing information on the Contractor change policy in:

a. The Member Handbook for new and existing members, and

b. The Provider Manual for providers

### 2. Address members' concerns

The current Contractor is responsible for promptly addressing members' concerns regarding availability and accessibility of services and quality of medical care. These issues include but are not limited to:

a. Quality of care

b. Case management responsiveness

c. Transportation service availability

d. Institutional care issues

e. Physician or provider office hours

f. Office waiting time, and

g. Network limitations and restrictions.

**3. Refer unresolved issues**

When quality of care and delivery of medical service issues raised by the member cannot be solved through the normal case management process, the current Contractor must refer the issue for review by:

a. The current Contractor's Quality Management Department and/or

b. The AHCCCS Medical Director

**4. Transitioning Between Contractors**

The current Contractor is responsible for:

a. Reporting the member's address and living arrangement changes to AHCCCS

b. Encouraging members to report anticipated moves to another county or geographic service area to them (current Contractor) and to the ALTCS local office prior to moving. Advance notice will facilitate continuity of service delivery.

c. Advising members to contact the ALTCS local office to request an enrollment change between Contractors serving a choice county if a valid reason other than medical continuity of care is claimed.

d. Accepting a member's request for an enrollment change to another county. The request may be verbal or in writing and may be addressed to the member's case manager.

e. Forwarding medical records and other materials to the receiving Contractor

Both the current Contractor and the receiving Contractor are responsible for assuring a safe transition for the member when an enrollment change occurs. The Contractors will transition within the requirements and protocols in the AHCCCS Medical Policy Manual, Chapter 500.

**5. Process Members' Enrollment Change Requests**

The Contractor will process enrollment change requests from members as follows:

| When the member requests a Contractor change | Then the current Contractor |
|---|---|
| Within a choice county and the member claims a valid condition exists | Refers the issue to the ALTCS local office for review using the ALTCS Member Change Report (DE-701). |
| That requires the approval of both the current and the receiving Contractors | Notifies the ALTCS local office if the member lives in a choice county or is moving to a choice county to initiate the Enrollment Choice Process.<br><br>Negotiates the change with the requested Contractor.<br><br>Completes a DE-621 and forwards it to the requested Contractor.<br><br>Notifies the member if the change is approved.<br><br>May forward the DE-621 to the AHCCCS Medical Director if the requested Contractor denies the change.<br><br>Notifies the member in writing if the enrollment change is denied at the Contractor level. The denial notice must include<br>• the AHCCCS Program Contractor Grievance Policy, and<br>• timeframes for filing a grievance. |

**6. Notify hospitals of certain enrollment changes**

When an enrollment change occurs while the member is hospitalized, the current Contractor must notify the hospital of the member's disenrollment prior to the enrollment with the receiving Contractor.

If the current Contractor fails to provide such notice to the hospital, the current Contractor will continue to be responsible for payment of hospital services provided to the member until the date notice is provided to the hospital as required in the AHCCCS Medical Policy Manual, Chapter 500.

**7. Process Grievances**

When an enrollment change requested by the member is denied by the Contractor (not the AHCCCS Medical Director), the current Contractor is responsible for processing any resulting grievances.

## H. AHCCCS Administration's Responsibilities

**1. Enrollment change requests received from members**

Except for valid changes within a choice county or a change due to the member moving to his or her own home, the AHCCCS Administration or the ALTCS local office will refer a member's request for an enrollment change to the current Contractor.

**2. Process enrollment change requests**

The AHCCCSA will process enrollment change requests within 5 days after the request is received, or all conditions for processing an enrollment change have been met, whichever is later.

**3. Issue decisions**

The AHCCCSA will notify Contractors of enrollment change approvals via the daily recipient roster. AHCCCSA will mail a new AHCCCS ID card to the member.

AHCCCSA will send notification to both the current and receiving Contractors and the member when an enrollment change is denied by the AHCCCS Medical Director. When approved by the AHCCCS Medical Director, notification will be sent to the current Contractor.

**4. Process Grievances**

When an enrollment change is denied by the AHCCCS Medical Director, AHCCCSA is responsible for processing all resulting member grievance.

The Division of Health Care Management, ALTCS Unit sends the member a denial notice, which explains the Grievance System under 9 A.A.C. 34.

**5. Monitor policy compliance**

The AHCCCS Division of Health Care Management (DHCM) will monitor Contractor compliance with this policy. Any violations of this policy, especially attempts to deny care or steer high cost or difficult members to another Contractor, will be considered contract violations and will be subject to sanctions up to and including contract termination.

## IV. References

- Arizona Administrative Code R9-28, Article 7
- ALTCS Contract, Section D
- AHCCCS Medical Policy Manual Chapter 500

# 404 - MEMBER INFORMATION POLICY

Effective Date: 11/17/97
Revision Date: 10/01/03

Staff responsible for policy: DHCM Operations

## I. Purpose

This policy applies to Acute Care and Arizona Long Term Care System (ALTCS) Contractors. This policy establishes guidelines for AHCCCS Contractors (and those who have been awarded contracts) regarding member information requirements and the approval process for member information materials developed by or used by the Contractors. This policy pertains to oral communication to members and materials, including outreach materials, that are disseminated to a Contractor's own members. It does NOT pertain to marketing or to outreach materials, that are disseminated to potential members, as described in Policy 101, AHCCCS Marketing, Outreach and Incentives, in chapter 100 of this manual. The exception is the written and oral information specifically mentioned in this policy.

## II. Definitions

**Member information materials:** Any materials given to the Contractor's membership. This includes, but is not limited to: member handbooks, member newsletters, surveys, and health related brochures and videos. It includes the templates of form letters and website content as well.

## III. Policy

### A. Oral Information

1. The Contractor must make oral interpretation services available to its members free of charge. Services for all non-English languages and the hearing impaired must be available.

2. The Contractor must make oral interpretation services available to potential members, free of charge, when oral information is requested for use in choosing among Contractors. Services for all non-English languages and the hearing impaired must be available.

## B. Printed Information

### 1. Materials Requiring Approval by the Administration

All member information materials developed by the Contractor and disseminated to its own members must be submitted to the AHCCCS Administration for approval, prior to dissemination.

### 2. Materials Not Requiring Approval by the Administration

Customized letters for individual members need not be submitted for approval. Health related brochures developed by a nationally recognized organization (see Attachment A) do not require submission to the AHCCCS Administration for approval. Attachment A is not an all inclusive list. Contractors may submit names of other organizations to AHCCCS to determine if they should be added to the list. Contractors will receive an updated copy of this Attachment, as necessary.

The Contractor will be held accountable for the content of materials developed by the organizations listed in Attachment A. AHCCCS suggests that the Contractor review the materials to ensure that: 1) the services are covered under the AHCCCS program; 2) the information is accurate; and 3) the information is culturally sensitive.

It is important to note that in all instances where the Contractor is required by its contract with AHCCCS to educate its members, brochures developed by outside entities must be supplemented with informational materials developed by the Contractor which are customized for the Medicaid population.

### 3. Reading Level and Language Requirements

All materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10% (whichever is less) of the Contractor members who also have limited English proficiency (LEP) in that language.

All vital materials shall be translated when the Contractor is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Contractor's members who also have LEP in that language. Vital materials must include, at a minimum, notices for denials, reductions, suspensions or terminations of services, consent forms, communications requiring a response from the member, informed consent and all grievance and request for hearing information included in the Enrollee Grievance System Policy as described in the "Enrollee Grievance System Standards and Policy" section of the Acute Care Contract.

All written notices informing members of their right to interpretation and translation services in a language, shall be translated when the Contractor is aware that 1,000 or 5% (whichever is less) of the Contractor's members speak that language and have LEP.

The Contractor is not required to submit to the AHCCCS Administration the member material translated into a language other than English, however, it is the Contractor's sole responsibility to ensure the translation is accurate and culturally appropriate.

The Contractor shall make every effort to ensure that all information prepared for distribution is written at the fourth grade level. The reading level and methodology used to measure it should be included with the submission.

The materials shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

4. All proposed Contractor member materials will be reviewed by the Division of Health Care Management. Information shall be submitted in a hard copy version or via electronic mail. Proposed materials shall be submitted to:

Acute Care Contractor Materials

Manager, Health Plan Operations (or her/his designee)
Division of Health Care Management, Mail Drop 6100
P. O. Box 25520
Phoenix, AZ 85002-5520
FAX: (602) 256-6421

ALTCS Contractor Materials

ALTCS Manager (or her/his designee)
Division of Health Care Management, Mail Drop 6100
P. O. Box 25520
Phoenix, AZ 85002-5520
FAX: (602) 256-6421

Proposed materials must be submitted 30 days before approval is desired. AHCCCS will notify the Contractor in writing within fifteen (15) working days of receipt of the complete materials packet whether or not the materials have been approved, denied or require modification.

**5. New Member Information**

Acute Care Contractors shall produce and provide the following printed information to each member or family within ten (10) days of receipt of notification of the enrollment date. ALTCS Contractors shall produce and provide the following printed information to each member or family within twelve (12) working days of receipt of notification of the enrollment date.

Member Handbook

**Both Acute and ALTCS Member Handbooks shall contain the following:**

a) A table of contents

b) A general description about how managed care works, particularly in regards to member responsibilities, appropriate utilization of services and the PCP's roll as gatekeeper of services

c) A description of all available covered services and an explanation of any service limitations or exclusions from coverage. The description should include a brief explanation of the Contractor's approval and denial process

d) How to obtain a PCP and change PCP

e) The handbook revision date

f) How to make, change and cancel appointments with a PCP

g) List of applicable co-payments, what to do if a member is billed, and under what circumstances a member may be billed for non-covered services.

h) Dual eligibility (Medicare and Medicaid); services received in and out of the Contractor's network and coinsurance and deductibles. See Section D, "Medicare Services and Cost Sharing" in the Contract

i) The process of referral and self-referral to specialists and other providers, including access to behavioral health services

j) How to file a complaint

k) What to do in case of an emergency and instructions for receiving advice on getting care in case of an emergency. In a life-threatening situation, the member handbook should instruct members to use the emergency medical services (EMS) available and/or activate EMS by dialing 9-1-1. The handbook should contain information on proper emergency service utilization.

l) How to obtain emergency transportation and medically necessary transportation

m) ESPDT services–A description of the purpose and benefits of EPSDT services, including the required components of EPSDT screenings and the provision of all medically necessary services to treat a physical or mental illness discovered by the screenings. Screenings include a comprehensive history, developmental and behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screening and immunizations.

n) Maternity and family planning services

o) Description of all covered behavioral health services and how to access these services

p) Out of country/out of state moves

q) All grievance and request for hearing information included in the Contractor's Enrollee Grievance System Policy as described in the "Enrollee Grievance System Standards Policy" section of the Contract

r) Contributions the member can make towards his/her own health, member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contactor. This shall include a statement that the member is responsible for protecting his or her ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's eligibility and/or legal action. A sentence shall be included that stresses the importance of members keeping, not discarding, the swipe ID card.

s) Advance directives

t) Use of other sources of insurance. See Section D, "Coordination of Benefits/Third Party Liability" in the contract

u) A description of fraud and abuse, including instructions on how to report suspected fraud or abuse

v) A statement that informs the member of their right to request information on whether or not the Contractor has physician incentive plans (PIP) that affect the use of referral services, the right to know the types of compensation arrangements the plan uses, the right to know whether stop-loss insurance is required and the right to a summary of member survey results, in accordance with PIP regulation

w) Members' right to be treated fairly regardless of race, religion, gender, age or ability to pay

x) Instructions for obtaining culturally competent materials and/or services, including translated member materials

y) The availability of printed materials in alternative formats and how to access them

z) The availability of interpretation services for oral information at no cost to the member and how to obtain these services

aa) Information regarding prenatal HIV testing counseling services

bb) Members' right to know about providers who speak languages other than English

cc) How to obtain, at no charge, a directory of providers

dd) The member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

ee) Female members may have direct access to preventative and routine services from gynecology providers within the Contractor's network without a referral from a primary care provider.

ff) Member's have the right to a second opinion from a qualified health care professional within the network, or have a second opinion arranged outside the network, only if there is not adequate in-network coverage, at no cost to the enrollee.

gg) Member's right to request a copy of his/her medical record at no cost.

**For Acute Care members, the member handbook shall also contain:**

a) Information on what to do when family size or other demographic information changes

b) How to contact Member Services and a description in its function

c) Description of all covered dental services and how to access these services, including the process for making dental appointments

d) How to access after hours care (urgent care)

e) How to change Contractors

**For ALTCS members the member handbook shall also contain:**

a) How to contact the case manager

b) Member's share of cost

c) Explanation of the Transition Program and services available

d) Detailed descriptions of all current residential placement options

e) Explanation of when Program Contractor Changes may occur.

Network Description

The description shall, at a minimum, contain information about primary care providers, specialists, hospitals and pharmacies. The description will include:

a) Provider name

b) Provider address

c) Provider telephone number

d) Non-English languages spoken

e) Whether or not the provider is accepting new patients

The information will also include any restrictions on the member's freedom of choice among network providers. **Because the information must be current**, these materials do not have to meet the requirements specified in Attachment B "Potential Member Summary Document", but can be in the same form as typical correspondence to members.

**This description of the provider network should also be available on the Contractors web site. The description must be in a searchable form, to allow ease of use by members and providers**

**6. Potential Member Information**

The Contractor shall have summary information about its network available for potential members. **The information must be updated at least quarterly**. This material shall be contained in a document, which meets the specifications listed in Attachment B "Potential Member Summary Document".

The information will contain at a minimum:

a) Providers including primary care, specialty, hospitals and pharmacy providers; and telephone numbers; and non-English languages spoken by providers.

b) A toll free telephone number that the potential member may call for additional information. The Contractor must supply the new member "Network Description" described above, if specific information is requested by a potential member.

## IV. References

- Title 42 of the Code of Federal Regulations (42 CFR) Part 438
- Arizona Administrative Code R9-22, Article 5
- Acute Care Contract, Section D
- ALTCS Contract, Section D

Attachment A

## NATIONAL ORGANIZATIONS RECOGNIZED BY AHCCCS

Ambulatory Pediatric Association
American Academy of Allergy, Asthma, and Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Ophthalmology
American Academy of Physicians
American Academy of Pediatrics
American Association of Cancer Education
American Association of Psychiatric Services for Children
American Association of Public Health Physicians
American Cancer Society, Inc.
American College of Allergy & Immunology
American College of Cardiology
American College of Emergency Physicians
American College Health Association
American College Medical Quality
American College of Nutrition
American College Obstetricians and Gynecologists
American College of Physicians
American College of Preventative Medicine
American Dental Association
American Diabetes Association
American Gynecological and Obstetrical Society
American Heart Association
American Hospital Association
American Institute of Ultrasound in Medicine
American In Vitro Allergy/Immunology Society
American Lung Association
American Medical Association
American Medical Directors Association
American Medical Women's Association
American Pediatric Society
American Public Health Association
American Red Cross
American Society for Adolescent Psychiatry
American Society of Anesthesiologists
American for Clinical Nutrition
American Society for Reproductive Medicine
American Venereal Disease Association
Arizona Department of Health Services
Ask Me3

Centers for Disease Control and Prevention
March of Dimes
Maricopa County Department of Health Services
National Perinatal Association
Susan G. Komen Foundation
U.S. Department of Health & Human Services
U.S. State Health Departments
World Medical Association

**ATTACHMENT B**

## POTENTIAL MEMBER SUMMARY DOCUMENT

The summary information document describing the Contractor's network shall meet the following criteria. Please not that this applies only to Acute Care Contractors.

A. "GSA XX" should be printed on the back of the materials. "XX" here represents the number (2,4,6,8,10,12, or 14) assigned to the GSA(s) described in the document.

B. One 11 by 17 inch sheet of standard 20 pound paper. 50 pound "opaque" offset paper can also be used.

C. The same kind of paper should be used consistently.

D. Any color of paper may be used.

E. The paper should be folded once in half to form an 8 ½ by 11 inch shape. The fold should be on the left, to be read from the top of the 8 ½ side to the bottom of the 8 ½ side.

F. The paper should not be glossy, dyed or recycled. It may be die cut (for rounded corners, scalloped edges etc.), but there should be a flat edge on the left side.

G. When provided to AHCCCSA (or its designated mailing house) the pages should not be wrapped, but should be boxed. The same size box for all the Contractor's flyers should be used and each box should contain the same count.

H. The count and the GSA number should be marked on the box and each box should have a sample piece taped on the outside of the box.

I. All sheets should face the same direction in the box.

J. The Contractor should have the total amount marked on the delivery slip. The delivery slip will be given to AHCCCSA (or its designated mailing house).

# 405 - CULTURAL COMPETENCY

Effective Date: 03/02/00
Revision Date: 12/01/03

Staff responsible for policy: DHCM Operations

## I. Purpose

This policy applies to Acute Care and Arizona Long Term Care System (ALTCS) Contractors. This policy describes the requirement that Contractors offer accessible and high quality services in a culturally competent manner.

## II. Definitions

**Competent:** Properly or well qualified and capable.

**Cultural competency:** An awareness and appreciation of customs, values, and beliefs and the ability to incorporate them into the assessment, treatment and interaction with any individual.

**Culture:** The integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs, and may be influenced by factors such as geographic location, lifestyle and age.

**Limited English proficiency (LEP):** Not being able to speak, read, or write or understand the English language at a level that permits one to interact effectively with health care providers or the Contractor.

**Member:** A person eligible for AHCCCS, who is enrolled with a Contractor.

**Provider:** A person or entity who is registered with AHCCCS and/or subcontracts with an AHCCCS Contractor to provide AHCCCS covered services to members.

**Subcontractor:**

1. A person, agency or organization to which a Contractor has contracted or delegated some of its management functions or responsibilities to provide covered services to its members; or

2. A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leased of real property) to obtain space, supplies, equipment or services provided under the AHCCCS agreement.

## III. Policy

### A. Cultural Competency Plan

Each Contractor must have a comprehensive cultural competency program, which is described in a written plan. The Cultural Competency Plan (CCP) must describe how care and services will be delivered in a culturally competent manner.

The Contractor must identify a staff member responsible for the CCP. If there is a change in the staff member responsible for the CCP, the Contractor must notify the Division of Health Care Management (DHCM).

The CCP must contain a description of:

#### 1. Education and Training

a. The training program consists of the methods the Contractor will use to train its staff so that services are provided effectively to members of all cultures. Training must be customized to fit the needs of staff based on the nature of the contacts they have with providers and/or members.

b. The education program consists of methods the Contractor will use for providers and other subcontractors with direct member contact. The education program will be designed to make providers and subcontractors aware of the importance of providing services in a culturally competent manner. The contactor must also make additional efforts to train or assist providers and subcontractors in receiving training in how to provide culturally competent services.

#### 2. Culturally Competent Services and Translation/Interpretation Services

The Contractor describes the method for evaluating the cultural diversity of its membership to assess needs and priorities in order to provide culturally competent care to its membership. Culturally competent care requires that the Contractor evaluate its network, outreach services and other programs to improve accessibility and quality of care for its membership. It must also describe the provision and coordination needed for linguistic and disability-related services. The availability and accessibility of translation services should not be predicated upon the non-availability of a friend or family member who is bilingual. Members may elect to use a friend or relative for this purpose, but they should not be encouraged to substitute a friend or relative for a translation service. A Contractor, at the point of contact, must make members aware that translation services are available. The services that are offered must be provided by someone who is proficient and skilled in translating language(s).

The Contractor must provide translations in the following manner:

a. All materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10% (whichever is less) of the Contractor's members who also have limited English proficiency (LEP) in that language.

b. All vital materials shall be translated when the Contractor is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Contractor's members who also have LEP in that language. Vital materials must include, at a minimum, notices for denial, reduction, suspension or termination of services, vital information from the member handbook and consent forms.

c. All written notices informing members of their right to interpretation and translation services in a language shall be translated when the Contractor is aware that 1,000 or 5% (whichever is less) of the Contractor's members speak that language and have LEP.

### B. Evaluation and Assessment of CCP

The Contractor must evaluate the CCP for effectiveness. Evaluations are to be made on an annual basis and a copy of the evaluation sent to DHCM. The evaluation may, for example, focus on comparative member satisfaction surveys, outcomes for certain cultural groups, member complaints, grievances, provider feedback and/or Contractor employee surveys. If issues are identified, they should be tracked and trended, and actions should be taken to resolve the issue(s).

## IV. References

- Balanced Budget Act of 1997 (BBA)
- BBA Regulations: Title 42 of the Code of Federal Regulations (42 C.F.R.) 438.306(e), 63 Fed. at 52021
- Title VI of the Civil Rights Act: Title 42 of the United States Code (42 U.S.C.) 2000d (see 45 C.F.R. 80, app. A (1994)
- Americans with Disabilities Act: 42 U.S.C., Chapter 126
- National Standards of Culturally and Linguistically Appropriate Health Care, Volume 65 of the Federal Register (65 Fed. Reg.) 80865-80897 (December 22, 2000)
- Title VI Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency, 68 Fed. Reg. 47311, (August 8, 2003)

## V. Web Addresses

http://erc.msh.org - Under Quick Links choose “Providers Guide to Quality and Culture”
www.ahrqpub@ahrq.gov - Choose “Minority Health
www.ahrq.gov/about/cods/cultcomp.htm - Oral, Linguistic, and Culturally Competent Services Guides for Managed Care Plans
www.ahrq.gov/consumer/espanoix.htm - Has information in both Spanish and English
www.diversityrx.org/BEST/ - Diversity Rx
www.hrsa.gov/OMH/ - Office of Minority Health
www.georgetown.edu/research/gucdc/nccc/nccc8.html - National Center for Cultural Competence
www.ahrq.gov/data/hcup/factbk3/factbk3.htm - Agency for Healthcare Research and Quality
www.lep.gov - Federal Governmental Web Address
www.usdoj.gov/crt/cor - Choose LEP Page
www.cms.gov/healthplans/quality/project03.asp - Centers for Medicare and Medicaid Services
www.languageline.com - Translation Service
www.cyracom.net - Translation Service
www.xculture.org - Cross Cultural Health Care Program (CCHCP)
www.omhrc.gov/cultural - Center for Linguistics and Cultural Competence in Health Care (CLCCHC)
www.mentalhealth.org/publications/allpubs/Ca-0015/default.asp - Substance Abuse and Mental Health Services Administration (Children’s Issues)
www.ama-assn.org/ama/pub/category/4849.html - Links to Cultural Competency Issues
www.cdcnpin.org/scripts/population/culture.asp - Centers for Disease Control
http://cecp.air.org/cultural/Q_howdifferent.htm - Center for Effective Collaboration and Practice
www.ems-c.org/cfusion/culture.cfm - Emergency Medical Services for Children (good resource page)

# 406 - ENROLLEE GRIEVANCE POLICY

Effective Date: 07/01/04

Revision Date:

Staff responsible for policy: DHCM Operations

## I. Purpose

This policy applies to all AHCCCS Contractors as described in the definitions section. This policy establishes guidelines and timeframes for the receipt, resolution and tracking of enrollee grievances by AHCCCS Contractors. This policy does not cover quality of care complaints, which are covered in Chapter 900 of the AHCCCS Medical Policy Manual.

## II. Definitions

**Action**: The denial or limited authorization of requested services, including:

- type or level of service
- reduction; suspension or termination of a previously authorized service
- denial, in whole or in part, of payment for a service
- failure to provide a service in a timely manner as set forth in contract
- failure of a Contractor to act within the time-frames specified in contract; and,
- for enrollees residing in a rural area with only one Contractor, the denial of an enrollee's right to obtain services outside the Contractor's network.

**Contractor**: A Managed Care Organization (MCO) providing health care to acute or long term care enrollees; and/or the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS), a Prepaid Inpatient Health Plan (PIHP) providing behavioral health services for eligible Acute Care enrollees; and/or ADHS, Children's Rehabilitative Services (CRS), a PIHP providing CRS-related services to eligible acute or long term care enrollees.

**Day**: Calendar day unless otherwise specified.

**Grievance**: An expression of dissatisfaction (formerly called complaints) about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

**Enrollee**: A person eligible for AHCCCS and who is enrolled with a Contractor. Also known as a member.

## III. Policy

### A. Enrollee Grievances

Each Contractor shall have in place a system and process to respond to and resolve enrollee grievances.

Enrollees may communicate a grievance to the Contractor either orally or in writing.

Contractors must acknowledge receipt of each enrollee grievance. This acknowledgement may either be orally or in writing. If an enrollee files a grievance orally, acknowledgement of receipt is understood.

Enrollee grievances must be submitted to the Contractor. AHCCCS will not accept oral grievances. Written grievances received by AHCCCS will be immediately forwarded to the Contractor for resolution.

The Contractor must ensure that individuals who make decisions on grievances have appropriate clinical expertise in treating the enrollee's condition if the grievance involves clinical issues or is regarding the denial of expedited resolution of an appeal.

If an enrollee requests a grievance response and the Contractor responds in writing, the response must be mailed within ten (10) days of receipt of the grievance. Otherwise, oral responses should be communicated to the enrollee as quickly as possible.

Contractor decisions on enrollee grievances cannot be appealed.

Contractors may, but are not required to, allow providers to file grievances on behalf of enrollees. If the Contractor allows providers to file grievances on behalf of enrollees, the grievance is subject to the same resolution timeframes and tracking requirements. Providers must have written authorization from the enrollee to file a grievance on the enrollee's behalf.

**B. Timeframes**

If the Contractor chooses to acknowledge receipt of an enrollee grievance in writing, the acknowledgement must be made within five (5) business days of receipt.

It is expected that many grievances can be resolved when received. Contractors should attempt to resolve all grievances as expeditiously as possible. Most grievances should be resolved within ten (10) business days of receipt but **in no case longer than ninety (90) days**.

There are no time limits for filing an enrollee grievance.

**C. Tracking**

Contractors are required to log and track all enrollee grievances, regardless of who within the organization receives the grievance or whether the grievance is received orally or in writing.

The enrollee grievance log must include:

- Enrollee name, AHCCCS identification number
- Date grievance received
- Date of grievance acknowledgement (same as received if grievance filed orally)
- Brief grievance description/category
- Staff assigned for disposition (optional)
- Disposition
- Disposition date
- Disposition cause of delay (if disposition is greater than 10 business days from date of filing), and
- Enrollee notification date (if grievance response is requested by enrollee)

The Contractor must monitor the enrollee grievance log and perform period trending analysis to identify problems and issues. Findings from this analysis must be used to improve quality of care and services.

## V. References

- Title 42 of the Code of Federal Regulations (42 CFR) Part 438, Subpart F
- Title 9 of the Arizona Administrative Code, Chapter 34, Article 2 (9 A.A.C. 34)
- AHCCCS Contract

## IV. Reporting Requirements

The Contractor shall submit an Enrollee Grievance Report quarterly. The deadline for submission of this report is 45 days following the end of the quarter. The report shall include the following:

A. Number of grievances received in the reporting period
   1. Total
   2. By the categories used in the Contractor's executive summary reports

B. Number of days to resolution
   1. Number resolved within 10 days
   2. Number resolved in 11 or more days, but less than 29 days
   3. Number resolved in 30 or more days, but less than 59 days
   4. Number resolved in 60 to 90 days
   5. Average days to resolution

Report A. and B. above by the current quarter, prior quarter and current quarter for the previous year. Identified trends and corrective action plans should be reported to the Contractor's Operational and Compliance Officer.

# 407 - MEMBER NOTICE FOR NON-COVERED SERVICES

Effective Date: 10/01/03
Revision Date:

Staff responsible for policy: DHCM Operations

## I. Purpose

This policy applies to Acute Care and Arizona Long Term Care System (ALTCS) Contractors. This policy applies to Acute Care and ALTCS members whenever payment is denied for services not covered under the State Plan.

## II. Definitions

Not applicable

## III. Policy

Notice of action shall be sent to the member whenever payment is denied for services not covered under the State Plan. These services are detailed in the Arizona Administrative Code as noted below.

For the Acute Care and long term care programs, Title XIX non-covered services found in the following citations apply:

- R9-22-201 (B)(10), (11)
- R9-22-205 (B)(2), (3), (4)(a), (b), (e)
- R9-22-207 (D)(1)
- R9-22-212 (E)(7), (8)
- R9-22-215(C)(3), (4)
- R9-22-215(C)(1)--[Acute Care only]

For the Acute Care (Title XXI) program, non-covered services found in the following citations apply:

- R9-31-201 (D)(8), (9)
- R9-31-205(C)(2), (3)(a)(b)(d)(f)

The member notice shall meet the standards as described in contract under the enrollee grievance standards and policies.

## IV. References

- Title 42 of the Code of Federal Regulations (42 CFR) 438.404(c)(2)

# 408 - SANCTIONS POLICY

Effective Date: 10/01/03
Revision Date:

Staff responsible for policy: DHCM Administration

## I. Purpose

This policy specifies the sanctions which may be imposed by the AHCCCS Division of Health Care Management (DHCM) in accordance with federal and state laws, regulations and the AHCCCS contract. This policy applies to all AHCCCS Contractors who are either Managed Care Organizations (MCO) or Prepaid Inpatient Health Plans (PIHP).

## II. Definitions

**Act:** The Social Security Act.

**Acute Care Contractor:** A contracted managed care organization that provides acute care medical services to AHCCCS members who are Title XIX or Title XXI eligible, and who do not qualify for another AHCCCS program. Behavioral health services are carved out and provided through the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS).

**Arizona Department of Health Services, Division of Behavioral Health (ADHS/BHS):** A Prepaid Inpatient Health Plan mandated to provide behavioral health services to Title XIX acute care and Title XXI members who are eligible for behavioral health services. Services are provided through the ADHS Division of Behavioral Health and its Contractors, the Regional Behavioral Health Authorities.

**Arizona Long Term Care System (ALTCS) Contractor:** A contracted managed care organization, that provides long term care, acute care, behavioral health, and case management services to Title XIX eligible elderly, physically or developmentally disabled individuals who are determined to be at risk of an institutional level of care.

**Balanced Budget Act of 1997 (BBA):** The federal law mandating, in part, that States ensure the delivery of quality health care by their managed care Contractors. CMS finalized the BBA Medicaid regulations which implement the corresponding provisions of the BBA June 14, 2002. Included in these regulations is 42 CFR 438.700 et seq. regarding sanctions.

**Children's Rehabilitative Services (CRS):** A Prepaid Inpatient Health Plan administered by the Arizona Department of Health Services. CRS provides services to Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive CRS related services.

**Contractor:** For the purpose of this policy, Contractor means, a Managed Care Organization providing health care services to acute or long term care members and / or a Prepaid Inpatient Health Plan providing behavioral health services to eligible acute care members and/or CRS related services to eligible acute or long term care members.

## III. Policy

### A. General

AHCCCSA may impose sanctions, including, but not limited to, temporary management of the Contractor, monetary penalties, suspension of enrollment, withholding of payments, suspension, refusal to renew, or termination of the contract or any related subcontracts in accordance with applicable Federal and States laws and regulations, and the AHCCCS contract. Prior to the imposition of a sanction, AHCCCSA may provide a written cure notice to the Contractor regarding the details of the non-compliance. The cure notice will specify the period of time during which the Contractor must bring its performance back into compliance with contract requirements. If, at the end of the specified time period, the Contractor has complied with the cure notice requirements, AHCCCSA will take no further action. If, however, the Contractor has not complied with the cure notice requirements, AHCCCSA will proceed with the imposition of sanctions.

Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation prepayment to be withheld, when applicable. The Contractor may appeal the decision to impose a sanction in accordance with Arizona Administrative Code (A.A.C.) R9-34-401 et seq.

### B. Basis for Imposition of Sanctions

AHCCCSA may impose sanctions for any of the following:

1. Substantial failure to provide medically necessary services that the Contractor is required to provide under law or the terms of its contract to its enrolled members

2. Discrimination among enrollees on the basis of their health status or need for health care services

3. Misrepresentation or falsification of information furnished to CMS or AHCCCSA

4. Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider

5. Imposition of premiums or charges in excess of the 1115 Waiver

6. Failure to comply with the requirements for physician incentive plan

7. Distribution directly, or indirectly through any agent or independent Contractor, of marketing or outreach materials that have not been approved by AHCCCSA or that contain false or materially misleading information

8. Failure to meet AHCCCS Financial Viability Standards

9. Material deficiencies in the Contractor's provider network

10. Failure to meet quality of care and quality management requirements

11. Failure to meet AHCCCS encounter standards

12. Failure to fund accumulated deficit in a timely manner

13. Failure to increase the Performance Bond in a timely manner

14. Failure to comply with any provisions contained in the contract, and/or

15. Failure to comply with applicable State or Federal laws or regulations.

**C. Types of Sanctions**

AHCCCSA may impose the following types of intermediate sanctions:

**1. Monetary penalties** The amount of the monetary penalty may vary depending on the nature of the Contractor's action or failure to act. Examples are as follows:

a. The maximum of $25,000 may be imposed per occurrence for the following actions:

1) Substantial failure to provide medically necessary services that the Contractor is required to provide under the terms of this contract to its enrolled members

2) Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider

3) Failure to comply with physician incentive plan requirements, and

4) Distribution directly, or indirectly through any agent or independent Contractor, of marketing or outreach materials that have not been approved by AHCCCSA or that contain false or materially misleading information.

b. The maximum of $100,000 may be imposed per occurrence for the following types of actions:

1) Discrimination among enrollees on the basis of their health status or need for health care services, and

2) Misrepresentation or falsification of information furnished to CMS or AHCCCSA.

**2. Temporary Management** Appointment of temporary management for a Contractor may be optional or required.

a. Optional Imposition. Optional imposition of temporary management may occur when AHCCCSA determines that:

1) There is continued egregious behavior by the Contractor, including but not limited to the bases described in III(B) or behavior which is contrary to any requirements in Sections 1903 (m) and 1932 of the Social Security Act

2) Substantial risk to enrollees' health due to non-compliance of the Contractor

3) Temporary management is necessary to insure the health of its members while:

a) The Contractor corrects the non-compliance in III.C.2.a.1), or

b) The Contractor reorganizes, or

c) AHCCCSA completes termination of the contract, or

4) The Contractor has violated a term of its contract, and temporary management is authorized by contract.

b. Required Imposition. Required imposition of temporary management will occur when AHCCCSA determines that a Contractor has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act or 42 CFR 438.700 et seq. AHCCCSA will:

1) Allow the Contractor's members the option to disenroll from the Contractor without cause, and

2) Notify the affected members of their right to disenrollment.

c. Hearing. For temporary management imposed pursuant to the BBA provisions, AHCCCSA may not delay the imposition of temporary management to provide a hearing before imposing the sanction. For temporary management imposed pursuant to State Law, AHCCCS will provide an opportunity for hearing prior to imposing this sanction unless public health, safety, or welfare requires emergency action .

d. Duration. AHCCCSA will not terminate the temporary management until it determines that the Contractor can ensure that the sanctioned behavior will not recur.

**3. Member enrollment related sanctions** AHCCCSA may sanction a Contractor by:

a. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll

b. Suspending all new enrollment, including auto-assignments, after the effective date of the sanction, and

c. Suspending payment for members enrolled after the effective date of the sanction until CMS or AHCCCSA is satisfied that the reason for the sanction no longer exists and is not likely to recur.

**4. Additional sanctions** AHCCCSA may impose additional sanctions as provided under State Laws, regulations, or contract to address areas of non-compliance.

**D. General Notification of Sanction to Contractor**

Written Notification. AHCCCSA will notify the Contractor by certified letter of the specific basis for the sanction and applicable sanction as follows:

1. If the Contactor continues non-compliance, the notification will include the type and amount (if applicable) of the sanction.

2. If the sanction involves a monetary penalty, the notification will state the amount which will be deducted from the Contractor's next monthly capitation payment.

3. The notification will include timelines for the imposition of the sanction.

4. If the sanction involves termination, the notification will include the information in E.2. below.

## E. Termination of the Contract

1. Cause for termination. AHCCCSA retains the right to terminate a contract when a Contractor fails to:

   a. Carry out the substantive terms of its contract, or

   b. Meet applicable requirements in Sections 1932, 1903(m**),** or 1905(t) of the Social Security Act.

2. Termination of contract. AHCCCSA will:

   a. Send the Contractor the pre-termination notice by certified mail. The notice will specify AHCCCSA's intent to terminate the contract, the reason for termination, and the time and place of the pre-termination hearing.

   b. After the hearing, AHCCCSA will give the Contractor written notice of the decision affirming or reversing the proposed termination of the contract. If the decision affirms the proposed termination, the effective date of the termination will be provided.

   c. In cases where termination is upheld as a result of the hearing, AHCCCSA will notify the affected members of the Contractor's termination and provide them with information regarding available Contractors in their Geographic Service Area.

## F. Notification to CMS

For sanctions imposed or lifted pursuant to the BBA (42 CFR 438.700 et seq.), AHCCCSA will provide CMS with written notice:

1. Whenever it imposes or lifts a sanction for any of the sanctionable items listed in III.B. The notice will specify the Contractor, the type of sanction, and the reason for the imposition or lifting of the sanction; and

2. The notice will be given no later than 30 days after it imposes or lifts a sanction.

## IV. References

- Balanced Budget Act of 1997
- Title 42 of the United States Code (42 USC) 1396b(m) [Section 1903 (m) of the Social Security Act]
- 42 USC 1396 u-2 (e) [Section 1932(e) of the Social Security Act]
- Title 42 of the Code of Federal Regulations (42 CFR) 438.700 et seq.
- Arizona Revised Statutes (A.R.S.) 36-2903M
- AAC. R-9-22, Article 6
- AAC R9-34-401 et seq.
- AHCCCS Contract

# 409 – NOTICES OF ACTION

Effective Date: 04/01/05
Revision Date:

Staff responsible for policy: DHCM Administration

## I. Purpose

This policy applies to all Acute Care Contractors, Arizona Long Term Care System (ALTCS) Contractors, Arizona Department of Health Services/Department of Behavioral Health Services (DBHS) and Arizona Department of Health Services/Childrens Rehabilitative Services (ADHS/CRS). The purpose of this policy is to provide further clarification to Attachment H1 in the AHCCCS Acute Care and the Comprehensive Medical and Dental Program contract, Attachment B1 in the ALTCS Contract, Attachment F1 in the AHCCCS DBHS contract and Attachment C1 in the AHCCCS CRS contract. It describes the circumstances under which a notice of action must be generated by the Contractor and provided to the member when a requested service is denied or given limited authorization. It also provides guidance to the Contractors about the procedures to follow when a request for a DBHS or a CRS service is directed to an Acute Care/ALTCS Contractor.

## II. Definitions

**Provider**: A physician, physician extender, a psychologist or other independent behavioral health practitioner.

**Contractor:** Acute Care Contractors, ALTCS Contractors, DBHS, CRS or any subcontractor to whom a Contractor delegates its responsibilities.

## III. Policy

A. When a requested service is denied or a limited authorization is given, there are four categories of authorization requests for which a denial may or may not require a notice of action. A sample notice of action is included in this policy as Attachment A. Suggested language for informing members of their right to receive the notice in a prevalent language and other formats is included in Attachment B. The categories and notice requirements are as follows:

1. A Contractor denial of a provider request for a service does require a notice of action

2. The denial of a member request for a service that requires a provider order, does not require a notice. It is expected that the Contractor would refer the member to their provider.

3. The denial of a member request for a service, over which the Contractor has the sole authority to approve or deny, requires a notice of action. This does not include requests for transportation for purposes other than health care.

4. The denial of a member request to the Contractor for a service, which a provider has declined to order, does not require a notice. As appropriate, it is expected a second opinion would be provided.

B. Regardless of the category of authorization request, if a member requests further recourse when a denial or limited authorization of a requested service is given, a notice of action must be provided to the member.

C. When a request for service that is the responsibility of DBHS and its subcontractors is received, the Acute Care Contractor shall issue a denial and provide a notice of action to the member. The reason given for the denial should explain that the Acute Care Contractor is not contracted with AHCCCS to deliver the service. The notice should also include information about the appropriate entity to which the request should be directed.

D. When a request is received by an ALTCS or Acute Care Contractor for a service to a CRS enrolled child, the ALTCS/Acute Care Contractor shall conduct a review of the request. If the service is presumed to be covered by CRS, the Contractor shall:

1. Notify CRS

2. Simultaneously inform the member that a 14-day extension is being taken (for a total of 28 days) to provide the decision to the member and provider.

CRS shall review the request and:

3. If CRS approves the service, it will notify the ALTCS/Acute Care Contractor. The ALTCS/Acute Care Contractor shall issue a notice of action denying the service and directing the member to CRS. The ALTCS/Acute Care Contractor shall inform the member that the Contractor will assist the member make contact with CRS.

4. If CRS denies the service for any reason, it will send no notice to the member, but will notify the Contractor of its decision. The ALTCS/Acute Care Contractor will then review the request for services. The provider will be notified if the request is approved. If the ALTCS/Acute Care Contractor denies or provides limited authorization of the request, the Contractor shall issue a notice of action to the member.

5. The timing of the above steps shall be as follows:
   a. Day 1 (day request is received) through Day 5 - ALTCS/Acute Care Contractor review
   b. Day 6 - Fax to CRS
   c. Day 7 through Day 15 - CRS review
   d. Day 16 - Fax to ALTCS/Acute Care Contractor
   e. Day 17 through Day 28 – ALTCS/Acute Care Contractor review and if applicable issue Notice of Action

E. When a request is received by an ALTCS/Acute Care Contractor for a child, who is not enrolled with CRS, but the Contractor determines that the child has a CRS condition and the service is related to that condition, the Contractor shall:

1. Initiate medical director to medical director communication for urgent requests.

   a. If the ALTCS/Acute Care Contractor will deliver the service, no notice will be issued. If CRS will provide the service, the ALTCS/Acute Care Contractor will proceed as in D. 3.

2. For non-urgent requests the ALTCS/Acute Care Contractor shall refer the child to CRS and issue a notice of action to the member denying the service. The ALTCS/Acute Care Contractor shall assist the member in contacting CRS as necessary.

F. When any Contractor forwards a request for a service to another Contractor, as described in this policy, the notification shall be in writing and associated documents supporting that request shall be included.

G. When any Contractor refers a member to another Contractor for eligibility determination or for services, the sending Contractor shall assist the member in making initial contact with the receiving Contractor.

## IV. References

- 42 CFR §438.210
- 42 CFR Part 438 Subpart F, Grievance System

SAMPLE

# NOTICE OF ACTION

TO: Date:

FROM:

You have asked that **INSERT**: Name of Contractor approve: **INSERT:** Describe services requested on behalf of the member in easily understood terms. We have reviewed your request and decided that: **INSERT**: Describe action taken (or intended to be taken) by Contractor, including the relevant dates, in member specific terms and in easily understood language.

Our decision is based on the following reasons: **INSERT:** The explanation of the Contractor's decision must be complete and in commonly understood language. It must specify the relevant laws, rules, policies, etc. for the action. The explanation must also be both member and fact specific, describing the member's condition and the reasons supporting the Contractor decision. Generic statements are not adequate. Any decisions to deny or reduce a service authorization request must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

You can ask us to look at our decision again. This is called an appeal. You can have someone help you appeal. Also, your doctor or other health care provider can appeal for you if you write telling us so. If you appeal you must contact us by **INSERT DATE**: no later than 60 days after the date of this Notice**.** You can write or call us to appeal. If you write your appeal, it must be received by **INSERT DATE**: 60 days from the date of the Notice.

Before we make our decision, you can give us any information that you think will be helpful. You can ask us to set up a meeting so that you can give us the information in person, or you can give it to us in writing. You can also see your case file, including medical records and other information about your appeal, before you give us information and before we decide the appeal. After we review your appeal, we will send you our decision in writing. This decision is called the Notice of Appeal Resolution.

We will make a decision within 30 days. However, you may ask for a faster review of your appeal. This is called an "expedited appeal." You can ask for a faster review if your life or health could be in danger or your ability to attain, maintain or regain maximum function would be damaged by waiting the normal 30 days for a decision on your appeal. If your health care provider tells us this, the appeal will be decided in 3 working days. You may also ask us to decide the appeal in 3 working days. If you ask us yourself and we agree, we will make a decision in 3 working days. If you ask for a faster review (expedited appeal), tell us how your health will suffer if we take 30 days to decide

your appeal. If we do not agree that a faster review is needed, we will write you within 2 days, and we will also try to call you. Then, we will decide your appeal within 30 days.

For all appeals, up to 14 more days may be taken to make a decision on your case. This is called an extension. If we want an extension, we will write you and tell you why it is needed. If you want an extension, you can ask for it by writing or calling us.

**TO REQUEST CONTINUED BENEFITS DURING THE INSERT: Name of Contractor APPEALS PROCESS**

You can ask that the services listed in this letter continue while we make a decision. If you want those services to continue, you must say so when you appeal. This applies if we are stopping or reducing an approved service ordered by your doctor or other health care provider that you are receiving now.. This also applies to a service we have denied if the doctor or other health care provider says that the service is a necessary continuation of a service that was approved before.. Your services will only be continued if you appeal by **INSERT DATE**: ( the later of: 10 days from the date of the Notice OR the intended date of the action). If you do not win your appeal, you will be responsible for paying for these services provided during the appeal.

If you have any questions about filing an appeal or if you need help, you can call us at **INSERT**: phone number. Please send your written appeal to: **INSERT:** address.

Sincerely,

**INSERT**: Name

# SAMPLE OF ALTERNATIVE LANGUAGE

Notices of action must be made available in the prevalent non-English languages of the contractor's membership. They must also be made available in alternative formats for those who for example, have limited visual acuity or have limited reading proficiency.

The following example (both paragraphs), if included in large bold print at the top of the notice, would meet that requirement.

In the prevalent languages:

> If you do not understand this notice, please call our office at XXX-XXX-XXXX and we will provide the notice in (prevalent language). If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

In English:

> If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

# 410 – CRS RECIPIENT INFORMATION POLICY

Effective Date: 07/01/04
Revision Date:

Staff responsible for policy: DHCM Administration

## I. Purpose

This policy applies to the Arizona Department Health Services/Children's Rehabilitation Services (CRS) and their subcontractors. This policy establishes guidelines for CRS and their subcontractors regarding recipient information requirements and the approval process for recipient information materials developed by or used by the CRS or its subcontractors. This policy pertains to oral communication to recipients and materials, including outreach materials that are disseminated to CRSA's own recipients.

## II. Definitions

**CRS:** A Program for children with covered conditions administered by the Arizona Department of Health Services (ADHS).

**CRSA:** Children's Rehabilitation Services Administration, located within ADHS.

**Recipient Information Materials:** Any materials given to CRSA Recipients including, but not limited to: recipient handbooks, recipient newsletters, surveys, and health related brochures and videos. It also includes the templates of form letters and website content.

## III. Policy

### A. Oral Information

CRSA must make oral interpretation services available to its recipients free of charge. Services for all non-English languages and the hearing impaired must be available.

### B. Printed Information

#### 1. Materials Requiring Approval:

a. It will be the responsibility of CRSA to assure that all materials and/or information provided by CRSA or its subcontractors meet the intent and requirements of this policy.

b. All recipient information materials developed by CRSA subcontractors, and disseminated to its own recipients should be submitted to the CRSA for approval, prior to dissemination.

c. AHCCCSA will review CRSA's member information monitoring activities and appropriateness of member materials during on-site AHCCCSA Audits.

**2. Materials not requiring approval by the CRSA:**

a. Customized letters for individual recipients need not be submitted for approval. Health related brochures developed by a nationally recognized organization (see Attachment A) do not require submission to the AHCCCS Administration for approval. Attachment A is not an all inclusive list. CRSA may submit names of other organizations to AHCCCS to determine if they should be added to the list. CRSA will receive an updated copy of this Attachment, as necessary.

b. CRSA will be held accountable for the content of materials developed by the organizations listed in Attachment A. AHCCCS suggests that CRSA and/or its subcontractors review the materials to ensure that:

1) The services are covered under the CRS and/or the AHCCCS program;
2) The information is accurate; and
3) The information is culturally sensitive.

c. It is important to note that in all instances where CRSA is required by its contract with AHCCCS to educate its recipients, brochures developed by outside entities must be supplemented with informational materials developed by CRSA or its subcontractors which are customized for the Medicaid population.

**3. Reading Level and Language Requirements**

a. All materials shall be translated when CRSA is aware that a language is spoken by 3,000 or 10% (whichever is less) of CRSA recipients who also have limited English Proficiency (LEP) in that language.

b. All vital materials shall be translated when CRSA is aware that a language is spoken by 1,000 or 5% (whichever is less) of CRSA's recipients, who also have LEP in that language. Vital materials must include, at a minimum, notices for denials, reductions, suspensions or terminations of services, consent forms, communications requiring a response from the recipient, informed consent and all grievance and request for hearing information included in the *Enrollee Grievance System Policy* as described in the "Enrollee Grievance System Standards and Policy" section of the CRSA Contract.

c. All written notices informing recipients of their right to interpretation and translation services in a language, shall be translated when CRSA is aware that 1,000 or 5% (whichever is less) of CRSA's recipients speak that language and have LEP.

d. It is CRSA's or it subcontractor's sole responsibility to ensure the translation is accurate and culturally appropriate.

e. CRSA shall make every effort to ensure that all information prepared for distribution is written at the fourth grade level. The reading level and methodology used to measure it should be included with the submission

f. The materials shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

**4. CRSA Recipient Handbooks Shall Contain the Following:**

a. A table of contents

b. A general description about how CRSA managed/specialty care works, particularly in regards to recipient/parental application process, general eligibility, medical eligibility, rights and responsibilities, appropriate utilization of services and the recipient's Acute Care PCP's role as gatekeeper of services, and a description of how services are coordinated between CRS and the recipient's PCP.

c. A description of all available covered services including the multidisciplinary team approach and an explanation of any service limitations or exclusions from coverage. The description should include a brief explanation of CRSA's and /or its subcontractor's approval and denial process.

d. The handbook revision date.

e. How to make, change and cancel appointments with a CRS Clinic Provider.

f. What to do if a recipient is billed, and under what circumstances a recipient may be billed for non-covered services.

g. The process of referral to specialists and other providers, including access to behavioral health services.

h. How to file a complaint.

i. What to do in case of an emergency and instructions for receiving advice on getting care in case of an emergency. In a life-threatening situation, the recipient handbook should instruct recipients to use the emergency medical services (EMS) available and/or activate EMS by dialing 9-1-1. The handbook should contain information on proper emergency service utilization.

j. How to obtain emergency transportation and medically necessary transportation.

k. All grievance and request for hearing information included in CRSA's *Enrollee Grievance System Policy* as described in the "Enrollee Grievance System Standards Policy" section of the Contract.

l. Contributions the recipient can make towards his/her own health, recipient responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor. A statement should be included that informs the recipient of the importance of having their AHCCCS ID card with them at each CRS Clinic visit.

m. Advocacy Information.

n. A description of fraud and abuse, including instructions on how to report suspected fraud or abuse.

o. A statement that informs the recipient of their right to request information on whether or not the CRS Clinic has physician incentive plans (PIP) that affect the use of referral services, the right to know the types of compensation arrangements CRSA and or its subcontractor uses, the right to know whether stop-loss insurance is required and the right to a summary of recipient survey results, in accordance with PIP regulation.

p. Recipients' right to be treated fairly regardless of race, religion, gender, age or ability to pay.

q. Instructions for obtaining culturally competent materials and/or services, including translated recipient's materials.

r. The availability of printed materials in alternative formats and how to access them.

s. The availability of interpretation services for oral information at no cost to the recipient and how to obtain these services.

t. Recipients' right to know about providers who speak languages other than English.

u. How to obtain, at no charge, a directory of providers assigned to each CRS Clinic to provide specialty services.

v. How to contact CRSA Services and a description of each clinic's specialties.

w. A list of CRSA's contracted acute care facilities.

x. A description of CRSA/Parent Advisory Council.

y. Information and Referral Services.

z. Medical Records and Information.

**C. Network Description**

1. The description shall, at a minimum, contain information about CRSA's and/or its subcontractor's providers, specialists, hospitals and pharmacies. The description will include:

   a. Specialty Clinic name

   b. Specialty Clinic address

   c. Specialty Clinic telephone number

   d. Clinic Provider telephone number

   e. Non-English language spoken by clinic providers

   f. Whether or not the specialty provider is accepting new patients

2. The information will also include any restrictions or an explanation of the recipient's freedom of choice among clinic providers. The materials can be in the same form as typical correspondence to members.

## IV. References

- Arizona Administrative Code R9-22-518; R9-28-507
- Acute Care Contract, Sec. D
- ALTCS Contract, Sec. D
- 42 CFR PART 438

**ATTACHMENT A**

Ambulatory Pediatric Association
American Academy of Allergy, Asthma, and Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Ophthalmology
American Academy of Pediatrics
American Association of Cancer Education
American Association of Psychiatric Services for Children
American Association of Public Health Physicians
American Cancer Society, Inc.
American College of Allergy & Immunology
American College of Cardiology
American College of Emergency Physicians
American College Health Association
American College Medical Quality
American College of Nutrition
American College Obstetricians and Gynecologists
American College of Physicians
American College of Preventative Medicine
American Dental Association
American Diabetes Association
American Gynecological and Obstetrical Society
American Heart Association
American Hospital Association
American Institute of Ultrasound in Medicine
American In Vitro Allergy/Immunology Society
American Lung Association
American Medical Association
American Medical Directors Association
American Medical Women's Association
American Pediatric Society
American Public Health Association
American Red Cross
American Society for Adolescent Psychiatry
American Society of Anesthesiologists
American for Clinical Nutrition
American Society for Reproductive Medicine
American Venereal Disease Association
Arizona Department of Health Services
Bright Futures

Centers for Disease Control and Prevention
March of Dimes
Maricopa County Department of Health Services
National Perinatal Association
U.S. Department of Health & Human Services
U.s. State Health Departments
World Medical Association